

The Modern Hospital

JULY 1951

**A.M.A. approves joint hospital accreditation • Survey
of hospital inventories • Outline for an institute on hospital
operation • Analysis of nursing services • Round table on
purchasing • Patient opinion poll • Report on chest x-ray program**



High on a San Francisco hilltop stands Maimonides Health Center—a proud structure devoted entirely to the care of the chronic sick. Every patient room faces south and has been given a floor-to-ceiling glass wall to provide a pleasant living environment and a tonic-effect view across the city. Beyond these picture windows are wind-sheltered, sunny balconies from which one may look downward into specially landscaped courts for other spirit-lifting experiences. Architecturally this fine building is as advanced as the rehabilitation program practiced within it.

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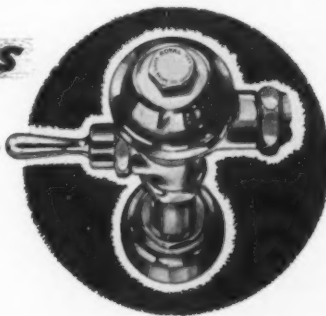
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The Modern Hospital

JULY 1951

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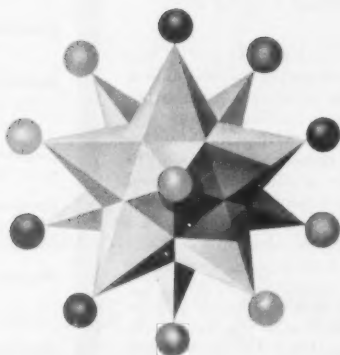
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AMONG THE AUTHORS

R. Ashton Smith was graduated from Yale University in 1938 with a B.A. degree and received his master's degree at Columbia University in June 1946. He completed courses in hospital administration in June 1947 and served an internship at University Hospitals of Cleveland from July 1947 to June 1948, following which he was awarded a master of science degree in hospital administration. He was appointed assistant superintendent of Muhlenberg Hospital, Plainfield, N.J., on July 1, 1948, and is still there. **Warren G. Ranier**, another member of the committee which reports the results of a nursing study made by the Assistant Hospital Administrators Society of New Jersey (see page 78), recently became acting administrator



Charles M. Smith

of the Mountainside Hospital at Montclair, N.J. He is a Columbia graduate in hospital administration and served his residency at Youngstown Hospital, Youngstown, Ohio. **Charles M. Smith**, assistant director of East Orange General Hospital and the third member of the New Jersey team, has been at East Orange since his discharge from military service in 1946. His work at the hospital is in the fields of statistics and finance.

James L. Bishop is director of patient and employee relations at New Britain General Hospital, New Britain, Conn., where he has developed the conference program described in his article on page 62. Before entering the hospital field two years ago, Mr. Bishop was personnel manager of the New Britain Machine Company. He is a graduate of Wesleyan University and has taught courses in personnel administration at New Britain Teachers College. As director of patient and employee relations at the hospital, Mr. Bishop is a combination personnel and public relations man.



James L. Bishop



Abraham Oseroff

Abraham Oseroff is chief executive of Pittsburgh Blue Cross and secretary of the Hospital Council of Western Pennsylvania. A veteran of the Blue Cross movement, Mr. Oseroff helped to organize the plan in Pittsburgh when he was director of the Montefiore Hospital there. Before entering the hospital field he was in the mercantile business, having been managing director of R. H. Macy and Co., Ltd., of London.

Mr. Oseroff was a member of the American Hospital Association's first council on hospital service plans and has served for many years on the Blue Cross Commission. Mr. Oseroff's article on page 94 of this magazine reports the results of a survey recently completed by Pittsburgh Blue Cross.

Malcolm G. Taylor, whose article on the Saskatchewan Hospital Services Plan was endorsed in advance of publication by the president of the Saskatchewan Hospital Association, is a Canadian who received his education at the University of California. Elected to Phi Beta Kappa, and awarded the university fellowship in political science for 1945-47, he received his doctor of philosophy degree in 1949. This article is excerpted from a chapter of his dissertation. Dr. Taylor lectured on public medical care at the school of social work and on social medicine at the faculty of medicine, University of Toronto. He is now director of research and statistics for the Saskatchewan Health Services Planning Commission.

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Reader Opinion

Construction Authority

Sirs:

We deeply appreciate your constructive suggestion recommending that the Public Health Service be delegated with authority for all phases of hospital construction and expansion.

You will be glad to know that we concur wholeheartedly with the facilities and personnel of the United States Public Health Service for coping with and serving the various hospitals in their construction and equipment problems.

Oscar R. Ewing, the administrator of Federal Security Agency, which is the claimant agency for all materials required in the field mentioned has named Charles G. Lavin of his office as the coordinator of this entire program. I am certain, therefore, that Mr. Lavin will be very happy to respond to any future requests or comments that you may wish to offer in connection with the hospital program served by your fine publication.

Manly Fleischmann
Administrator

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Credit Where It Is Due

Sirs:

The tear sheet from the April issue of *The MODERN HOSPITAL* containing the "Specifications for a Therapeutic Pool" has been received.

The American Physical Therapy Association and the National Foundation for Infantile Paralysis welcomed the opportunity to make this material more widely known. We are embarrassed, however, to have Miss Haskell given credit as the author. This was developed cooperatively by the association and the national foundation. The text was written largely by the architect.

Mildred Elson
Executive Director

American Physical Therapy Association
New York City

Oldest Hospital?

Sirs:

In regard to the article in May 1951 issue in which it is stated that Pennsylvania Hospital's claim to be the oldest hospital in the United States is "a claim disputed only locally," I should like to call to your attention the fact that Charity Hospital of Louisiana at New Orleans was founded 15 years earlier than the Pennsylvania Hospital.

The following quotation from the *Louisiana Historical Quarterly* (Vol. 31, No. 1, Jan. 1948, p. 9) furnishes proof of Charity Hospital's claim to be the oldest general hospital in the nation:

"The first New Orleans hospital devoted exclusively to this purpose (to



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accept poor patients who had not the means to pay) was established in 1736. Known as St. John's and also as the Hospital for the Poor, it was the original Charity Hospital of New Orleans, (Contract for Building Hospital for the Poor, June 10, 1736, Cabildo Archives, Document 5740) and it began the free medical service to the poor which has continued to the present time, and which is now dispensed from the vast medical center known as the Charity Hospital of Louisiana at New Orleans. This date of foundation and the fact that in 1737 there were actually four or five patients

receiving treatment (Memorial by Bien-ville and Salmon to Minister in France, May 20, 1737, typewritten facsimile of the copy in the Library of Congress, in personal possession) establishes Charity Hospital as the oldest hospital in the United States."

Stella O'Connor

New Orleans

Sirs:

The Pennsylvania Hospital claims to be the first hospital in what is now the United States. This claim is based on authentic source material, such as the

managers' minute books from the beginning to the present day; Benjamin Franklin's own statement in his autobiography, and the many manuscripts in the hospital's historical collection. These show a definite, unbroken line with the hospital functioning as a hospital first in its temporarily rented building.

Occasionally, a misguided friend of the Pennsylvania Hospital claims it to be the oldest in America. We do not claim to be the oldest in *America* for the very good reason that there is a hospital in Quebec founded in 1639, and one in Mexico City founded by Cortez in 1524.

The claim of "first" is sometimes made for the Bellevue Hospital, New York City; Charity Hospital, New Orleans, and Philadelphia General Hospital, Philadelphia, but these institutions started as almshouses and later developed into hospitals. The line of development and the line of succession of various institutions of the three cities are not always clear. In the case of the Charity Hospital, I quote from an article by the late Francis R. Packard, M.D., one of the outstanding medical historians of the day.

"In 1736 L'hospital des pauvres de la Charite was founded in New Orleans, which in 1815 was renamed the Charity Hospital of New Orleans. As Dr. Fossier, who has written an admirable account of the institution, says of its earlier years: 'Nothing today is known about the medical management of this hospital. Apparently the professional men played but a small part in the life of that institution.'"

Pennsylvania Hospital was established to care for sick persons; patients who were without funds were cared for without charge; those who had the means paid little, or what was determined to be the actual cost at the time. The emphasis, of course, was on the poor, but indigency was not a factor in determining admission.

In the case of each of the almshouses, indigency was the *primary* factor in determining admission; since poor people become ill, as well as others, once they had been admitted to the almshouse it was necessary for the overseers of the poor, or their equivalent, to take care of the poor when they became ill. This was done in some cases by contract with local physicians but this did by no means establish the institution as a hospital.

Florence M. Greim

Assistant to Administrator

Pennsylvania Hospital
Philadelphia



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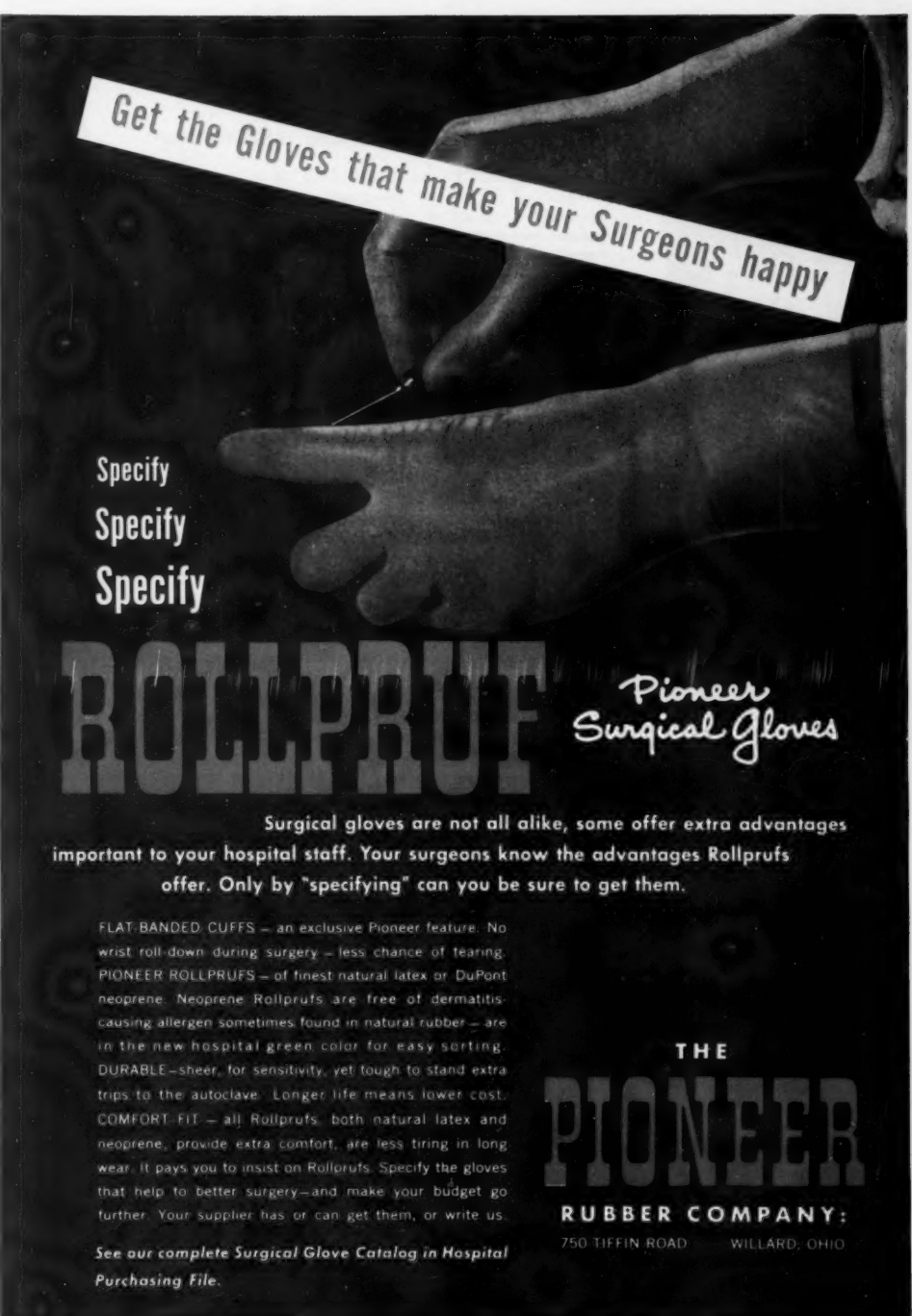
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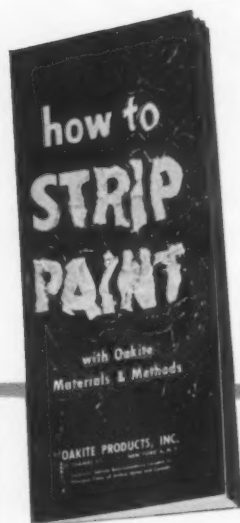
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Roving Reporter

Hospital Day Gets Everyone Into the Act

Hospitals are missing a sure thing when they fail to take advantage of National Hospital Day and the opportunity its observance gives them for improving their community relations.

This opportunity had slipped through the hands of the three general hospitals in Evansville, Ind., for some years. But this year, alerted to the possibilities and potentialities therein, an all-out program was planned and carried out.

The opening on Monday, May 14, of the third annual community enrollment in the Blue Cross-Blue Shield plans tied in with the hospital day slogan "Prepare Yourself Today for a Possible Hospital Stay Tomorrow With Membership in a Prepayment Insurance Plan." Promotion and publicity reflected the joint endeavors of hospital and plan personnel.

Open house between the hours of 2 and 4 o'clock Saturday afternoon was scheduled at each hospital. Thoroughly trained hospital personnel accompanied guests through the hospitals. Special departments were featured, such as the departments of physical therapy, laboratory and x-ray. The hundreds of instruments used in surgery also were on display. All three hospitals maintain their own approved schools of nursing and the tours concluded at the nurses' home where refreshments were served.

In an orientation program, the hospitals told the community of 130,000 population that each of the hospital pharmacies stock from 7000 to 10,000 items which are available for use at the drop of a prescription blank; that the total number of patient days for the

three hospitals was 182,206; that these three hospitals had a total operating cost last year of approximately \$4,000,000, and that a total of approximately 1,000,000 tests were run in the hospital laboratories in 1950, a figure which was difficult for some of the community to comprehend.

Newspaper publicity, saluting the hospitals and urging attendance at the open house ceremonies, was centered in a special section of the two daily newspapers. Featured was a report of plans for new buildings, additional facilities, and remodeling under way now or planned for the near future. The advertising of local business firms underwrote the cost of this special section.

The four local radio stations cooperated by the use of spot announcements throughout the week inviting the public to visit the hospitals on Saturday. News broadcasts included mention of the observance of National Hospital Day and the open house celebration.

In addition, a half-hour show on Friday evening dramatized the importance of the hospitals to the community and took one patient through his admission to the hospital and surgery. The administrators of the three hospitals participated in a question and answer period at the close of the broadcast.

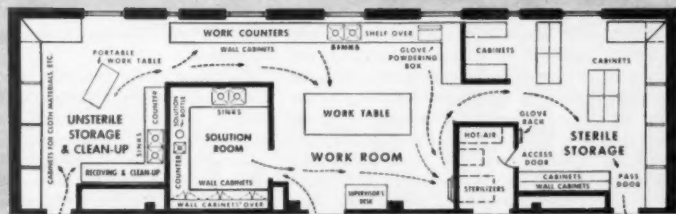
Local merchants granted permission for the use of show windows for hospital displays and some Blue Cross promotion was tied in with each. One window pointed up the rising costs of hospital care, one featured nursing care, and the third showed hospital equipment. Two additional windows featured community enrollment.

Over the week end, by the use of every available publicity medium the Blue Cross-Blue Shield community enrollment was heralded, beginning with publication of the mayor's proclamation of community enrollment week which urged Evansville citizens to look into the benefits offered.

Two hundred lamppost signs appeared in the downtown section and on main traffic arteries. Marquee signs at a number of business places carried announcements of the community enrollment week. Three motion picture houses used the Blue Cross plan's moving picture shorts.



Administrator Crayton E. Mann greets Sherrill family, patients at Baptist Hospital more than 12 times in the last five years.



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Consult Blickman's Planning Service for Efficient Layout of Central Supply and Other Departments

• Let Blickman hospital consultants help you plan the best layout for your cabinets, casework, counters, sinks. Their knowledge is based upon actual experience with the problems of many leading institutions. The layout they recommend will be based on your own hospital procedures, and will indicate the best and most efficient work-flow as shown by your specific operations.

To make sure that you get the efficiency planned for, Blickman follows through with the design and construction of individual units, and final installation. With this 3-fold service — planning, fabrication, installation — you are assured of equipment that will endure for years. Blickman's famous all-welded stainless steel construction, in fact, can be expected to last for the life of the building. Both *permanence* and hospital-standard *cleanliness* are built into these units. The smooth, crevice-free surfaces are easy to clean, remain permanently bright. Rounded corners in sinks and similar units are other important aids to sanitation. Maintenance and replacement costs are practically eliminated.

If you are considering new construction, renovations or additional equipment for Central Supply — or any other department — it will pay you to consult with Blickman first!



CENTRAL SUPPLY ROOM — St. Peter's Hospital, Albany, N. Y. — Blickman-Built sanitary stainless steel equipment helps safeguard procedures, never needs painting, will last for years.



SOLUTION ROOM — St. Peter's Hospital, Albany, N. Y. — equipped with Blickman-Built all stainless steel units, for maximum sanitation with effortless cleaning.



Send for Bulletin 10-CBC — illustrating and describing Blickman-Built cabinets and casework . . . The services of our consulting staff are at your disposal, to help plan Central Supply and Utility Rooms, Milk Formula Rooms, Laboratories, Diet Kitchens and other departments of your hospital.

S. Blickman, Inc., 1507 Gregory Avenue, Weehawken, N. J.
New England Branch: 845 Park Square Bldg., Boston 16, Mass.

Blickman-Built
Hospital Equipment

Paper napkins bearing the plan's emblems and the message "Community Week—Enroll Now" were used in leading restaurants, hotels and the hospitals, and information and enrollment booths were set up downtown and in neighborhood shopping centers. Outstanding among these attractive centers was the 40 foot house trailer parked on the main street where Blue Cross-Blue Shield personnel answered questions and accepted applications.

The transit company gave permission for the use of cards in the city's buses and the FM radio broadcasts piped into

the buses reminded passengers of the community enrollment. Other radio promotion included two half-hour shows, one dramatic presentation and one round table discussion featuring the civic leaders who were spearheading the drive. An on-the-spot recording at the trailer information center was broadcast. Three interviews were granted and five 15 minute disc jockey shows were devoted to the drive. Announcements of reservations for a breakfast for Blue Cross-Blue Shield enrollment and its public relations staff, where an hour long breakfast show originated, brought

another opportunity for good publicity. In addition to news reports on the progress of the drive, the radio stations used 150 spot announcements during the week.

The curator of the Evansville museum worked out a display comparing hospitals of the past with those of today. This will be a permanent exhibit.

The greatly broadened program available under the 120 day comprehensive plan for hospital care and the surgical-medical care plan were presented through the newspapers in pictures, news, feature stories and advertising sponsored by the hospitals and medical society.

One picture featured a Blue Cross-Blue Shield member still in the hospital with a bill exceeding \$2000. Another featured the 93 year old man who signed up for membership for himself and his 72 year old wife. The latter drew attention to the protection of the elderly and others ordinarily not eligible for protection against the cost of hospital and medical care. The newspapers published by the two labor unions in Evansville gave assistance through front page stories.

The ministerial association pledged its support, and various churches gave space in their bulletins to the opportunity afforded by the community enrollment for protection of the aged, self-employed and others not eligible for group enrollment.

Payments by the Blue Cross-Blue Shield plans to the hospitals and doctors of this area have exceeded \$2,275,000. Based on the payments during the first three months of this year and on the increasing membership in this area, Blue Cross expects to pay at least \$1,000,000 to the Evansville hospitals for the care of local people. Payments to physicians by the Blue Shield plan should be about \$500,000.

As is apparent, such an ambitious program as was carried out here could never have been launched without the wholehearted support of every segment of the community. This could not be won for such an occasion as our hospital day and community enrollment if the hospitals, the medical society and the local Blue Cross-Blue Shield office did not strive all year long for better acceptance and understanding on the part of the people of Evansville and Vanderburgh County.—CRAYTON E. MANN, administrator, Welborn Memorial Baptist Hospital, and JEAN JOHNSTON, public relations, Indiana Blue Cross-Blue Shield Plan, Evansville.



Marlite plastic-finished wall and ceiling panels eliminate periodic painting and redecorating expenses . . . reduce overhead. *Maintenance costs go down when Marlite panels go up!*

Modern, attractive Marlite keeps its beauty—the plastic finish seals in the sparkling, lustrous colors. Smudges and stains whisk away with a damp cloth. The large panels go up quickly over old walls or new, banish lingering paint odors and re-

decorating muss and fuss . . . keep their sanitary appearance and are so much easier to clean and keep clean.

For entrances, waiting rooms, lobbies, offices, wards, kitchens, nurseries, operating rooms, laboratories, patient rooms, and other areas where practical beauty is desired—*Modernize with Marlite*. See the 63 smart pattern and color combinations at your lumber and building material dealer's now. Or mail coupon below.

for creating beautiful interiors



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Subsidiary of Masonite Corporation

Without obligation, please send full-color Marlite literature showing typical installations, patterns and colors available, and other helpful remodeling and building information.

Name _____
Hospital _____
Address _____
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HOLY CROSS HOSPITAL, Salt Lake City

Saves \$14,400 yearly

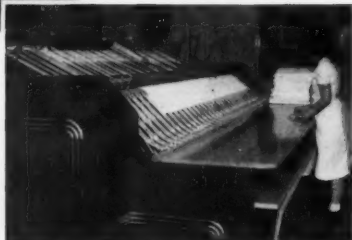
... with New "AMERICAN"
Equipped Laundry



▲ CASCADE End-Loading Washer with Type "A" Semi-Automatic Control (left), and 2 CASCADE Automatic Unloading Washers with Full-Automatic Controls (between Washers) at Holy Cross Hospital.

◀ Excess water is gently removed from washed work in NOTRUX and Solid Curb (right) Extractors. NOTRUX loads are changed in less than a minute by push-button operated electric hoist.

TRUMATIC Folder on 6-Roll SUPER-SYLON Flatwork Ironer automatically quarter-folds large linens lengthwise, requiring only one receiving operator who cross-folds and stacks work.



Management of 200-bed Holy Cross Hospital reports *savings in time, labor and costs* since installation of new AMERICAN equipped laundry department.

Our Laundry Advisor made a detailed study of the Hospital's clean linen requirements, then recommended high - production, labor - saving equipment to assure economical operation for years to come. As a result of installing this machinery, the Hospital reported the following benefits—

- Saved \$1,200 monthly in laundering costs.
- Three fewer operators required.
- Reduced work week 6¾ hours.
- Faster return of linens to service.
- Lower linen inventory.
- Better quality work.

Hundreds of hospitals are making remarkable savings with modern AMERICAN equipment. DON'T WAIT . . . INVESTIGATE the savings you can make with high-production AMERICAN laundry machinery. WRITE TODAY . . . for our Laundry Advisor to call at your convenience. His services are available to hospitals, large or small, *without any cost or obligation whatever.*

Remember . . . Every Department of Your Hospital Depends on the Laundry.

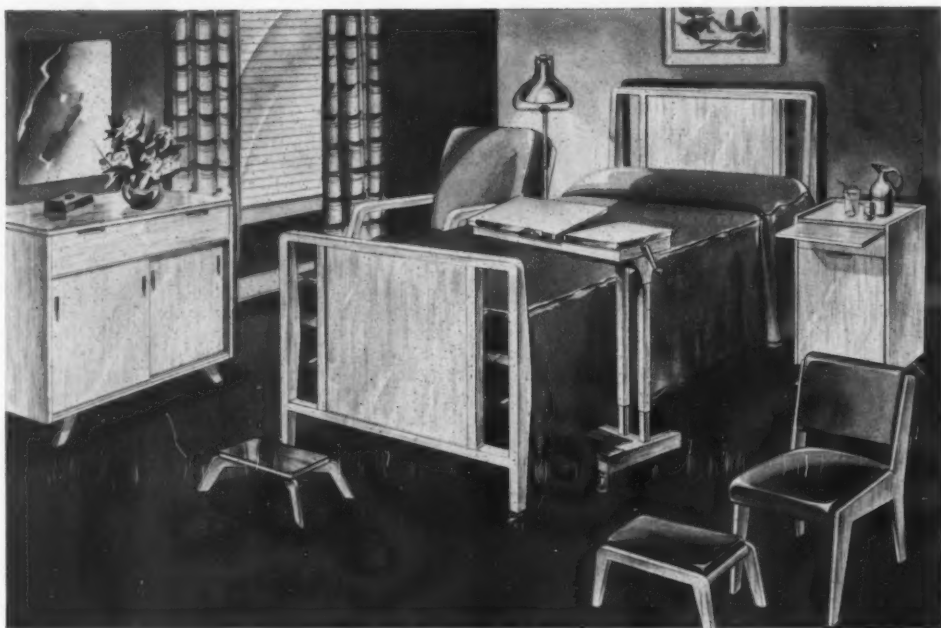


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LAUNDRY MACHINERY CO.

CINCINNATI 12, OHIO

Newest design

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HARD'S New Room Groups in beautiful warm woods!

This is our new line of hospital furniture. It is smartly-styled to combine the simplicity of clean, functional design with the warmth of real wood finishes. And it blends beautifully with modern hospital decor.

It is superbly constructed of solid birch parts and birch-faced plywood. All exposed plywood edges are veneered, and all main joints are rigidly supported. It will give you many years of trouble-free service . . . the same kind of service that HARD furniture has been giving for the past 75 years.

Sold exclusively through selected surgical supply dealers. Ask your dealer for the brochure describing this beautiful new addition to the HARD line of Life-Long products.



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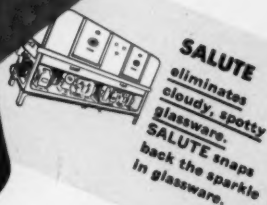
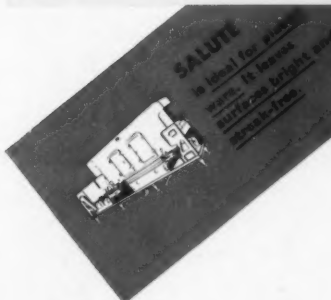
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SALUTE

For the best machine
dishwashing in history!

Out of years of research and field testing comes SALUTE*, a dishwashing compound so radically new that it can outperform any other product on the market today!

A combination cleaner-destainer, new SALUTE offers superior detergency and highest water softening action. With these improvements alone, SALUTE is an outstanding product!



• For use in ALL dishwashing machines

The results of nationwide field tests have convinced us of the superiority of new SALUTE. But let us convince you. Call your Wyandotte Representative or Supplier today for a demonstration.

* Featured at the Restaurant Convention in Chicago—May 7 to May 11



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Rx

In those difficult-to-control
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VERILOID*VPM

VERILOID PHENOBARBITAL MANNITOL HEXANITRATE

Reduces the Incidence of Side Actions

When side actions have proved an obstacle to proper dosage adjustment, Veriloid-VPM usually makes possible continuation of therapy. Containing per tablet Veriloid, 2 mg., phenobarbital, 15 mg., and mannitol hexanitate, 10 mg., Veriloid-VPM is indicated in all forms of hypertension regardless of severity. Blood pressure is reduced by the specific hypotensive properties of Veriloid—a distinctive biologically assayed fraction of *Veratrum viride*, the vasorelaxing action of mannitol hexanitate, and the sedative influence of phenobarbital. This combination raises the nausea threshold, thus allowing many patients who have been found intolerant to Veriloid to benefit from Veriloid-VPM.

The average dose of Veriloid-VPM is one to one and one-half tablets four times daily, after meals and at bedtime. Detailed information available on request. Veriloid-VPM is supplied in bottles of 100, 500, and 1,000 scored tablets.

P.S.

For the physician who prefers plain Veriloid, this unique *Veratrum* fraction is available as usual in 1, 2, and 3 mg. scored tablets. Veriloid has produced outstanding results in hypertension of all degrees, lowering the blood pressure without loss of the postural reflexes so necessary for normal living.

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IN ALL DEGREES OF HYPERTENSION

it's new, distinctive
and so very
functional!

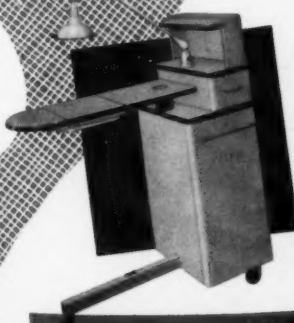
the Nightingale



● Truly, the NIGHTINGALE sets a new standard in patient room furniture. It provides new convenience and comfort for patients. It makes self-service a series of enjoyable interludes—thus, reduces the number of patient calls substantially.

● The Nightingale offers far more than the overbed table, the bedside cabinet and the bed light combined. It saves space and reduces cleaning and maintenance time. And add to all of these advantages the Nightingale's modern, functional beauty which contributes amazingly to any room in which it is placed.

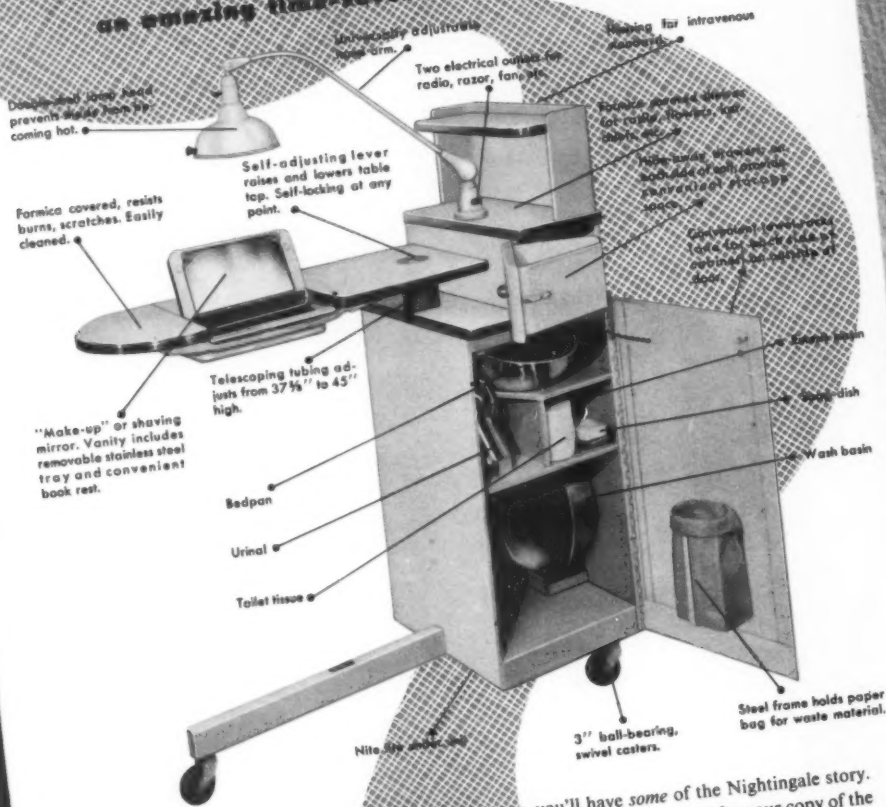
● The three pictures on this page begin to tell the Nightingale story. On the reverse side of this page you'll find more of the story in terms of specific features. For the entire story (which we think you'll want), write us for your copy of the Nightingale brochure.



AMERICAN HOSPITAL SUPPLY CORPORATION
GENERAL OFFICES • EVANSTON, ILLINOIS

the Nightingale

the ultimate in convenience for patients...
an amazing time-saver for personnel



● THE NIGHTINGALE is beautifully designed and durably built for years of unexcelled service. It is finished in a variety of attractive colors to harmonize perfectly with any color scheme. After you've read this page and the reverse side of this

page, you'll have some of the Nightingale story. For the complete story, write for your copy of the Nightingale brochure. See if you don't agree that here is the finest innovation in patient room furniture in many, many years.

AMERICAN HOSPITAL SUPPLY CORPORATION
GENERAL OFFICES - EVANSTON, ILLINOIS

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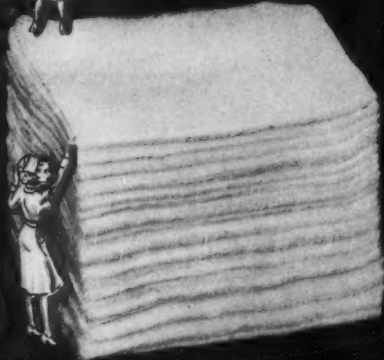
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Dressing Volume
**Can Reduce
 Your Cost**



24 Gauze Sponges 4" x 4"
 16-ply after sterilization



24 Zobec Sponges 4" x 4"
 after sterilization



Doctors and nurses don't count the number of sponges for a post-operative dressing. They use a sufficient number to obtain the desired thickness or "dressing volume." • You can reduce your cost of surgical dressings by using Zobec Sponges for post-operative dressings because each Zobec Sponge has more individual "dressing volume." Fewer Zobec Sponges are required.

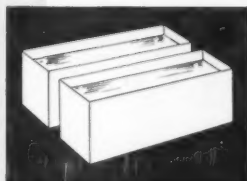
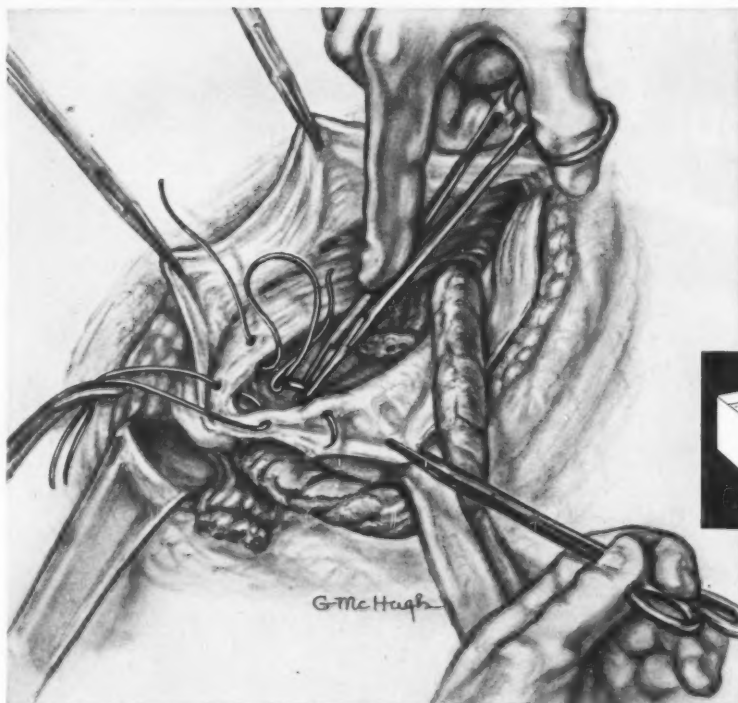
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DOUBLE BATH DOES IT

Two baths are better than one, for *total* chromicizing. This *Curity* process means that every strand is fully, evenly chromicized, without "weak spots," for an absorption rate you can count on.

Successful hernioplasty requires sutures with a thoroughly predictable absorption rate.

To this end, the *Curity* Laboratory developed its technic of total, "double-bath" chromicization.

Curity Sutures are immersed in two baths. The first bath permeates the entire strand, then combines with the molecules of the second bath to produce a uniformly chromicized suture . . . from the inside out.

What is more, this technic makes possible chromicizing *after the suture strand is formed*, and thus retains the natural mucin bond of the strand material, for a stronger and more uniform suture.

Total chromicizing is another contribution to the science of suture making from the laboratory that, through the years, has made so many important contributions in your interest.



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Dictation is EASIER.



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 SOUNDWRITER

AUDOGRAPH sales and service in 180 principal cities of the U.S. See your Classified Telephone Directory—under "Dictating Machines." Canada: Northern Electric Company, Ltd., sole authorized agents for the Dominion. Overseas: Westrex Corporation (export affiliate of Western Electric Export Company) in 35 foreign countries.

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- THE GRAY MANUFACTURING COMPANY, HARTFORD 1, CONNECTICUT
- Send me Booklet 7-P—"Saving The Doctor's Time."
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- Street.....
- City..... State.....

Learn **YOUR COFFEE COST** *to 1/10¢ per cup*

Learn
**how to serve even better
coffee for no more
than your present cost**

Do you know your coffee cost exactly?
How many full cups you get per pound?
Whether your coffee is brewed correctly
and stored at the right temperature?
Whether your cream blend is correct for
the type of coffee you serve?

Without Obligation . . . **Let the Maxwell House
Coffee Clinic analyze your coffee service completely**

Now . . . the Maxwell House Coffee Clinic will answer all the above questions for you—dozens more! Your General Foods man has been trained in the use of special testing equipment to analyze your coffee service. He'll show you how to make your coffee service even better!

What's more, he'll show you how to serve this better

cup of coffee for no more than you now pay.

Never before has such a complete analysis been available. So call your General Foods man right now. He'll arrange a Clinic in your restaurant at a time convenient for you. Or write: Institution Department, General Foods Corporation, 250 Park Ave., New York 17, N. Y.

**PEOPLE WHO TALK ABOUT GOOD FOOD...
TALK ABOUT GENERAL FOODS!**



"THE GENERAL FOODS MAN ANALYZED MY COFFEE SERVICE. I ADOPTED HIS PROGRAM. IT WORKS! NOW I HAVE A LOWER FOOD COST—EVEN BETTER COFFEE!"

says WILLIAM KLEIN
Hotel Metropole, Cincinnati, Ohio

"Even though I don't use Maxwell House, the General Foods man analyzed my service. I was amazed at what I learned. It's possible to program my coffee service in a profitable way!"

says ROBERT G. WHITENACK
Bob Whitenack's Grill, Cincinnati, Ohio

"I had trouble controlling my coffee costs until the General Foods man showed me his program. Now I find my costs are down, my coffee is better!"

says WARREN H. DORSEY
Lexington Room of the Kentuckian Hotel
Lexington, Kentucky

How to make **TALK** work for you!

Naturally folks are pleased when you serve their favorite foods and beverages. And just as naturally they'll tell their friends about your thoughtfulness. That's why it pays to serve brands you know folks will like. That means famous brands like the special restaurant blend of Maxwell House

Coffee, America's largest-selling brand, Jell-O Desserts, Log Cabin Syrup, and all the other General Foods Institution Products. The people you serve have enjoyed these wonderful products in their own homes for years. Contact your G.F. man or distributor for service.



AREN and AREX

*Begin with Quality . . .
Carry through with Service . . .
Add up to Economy*

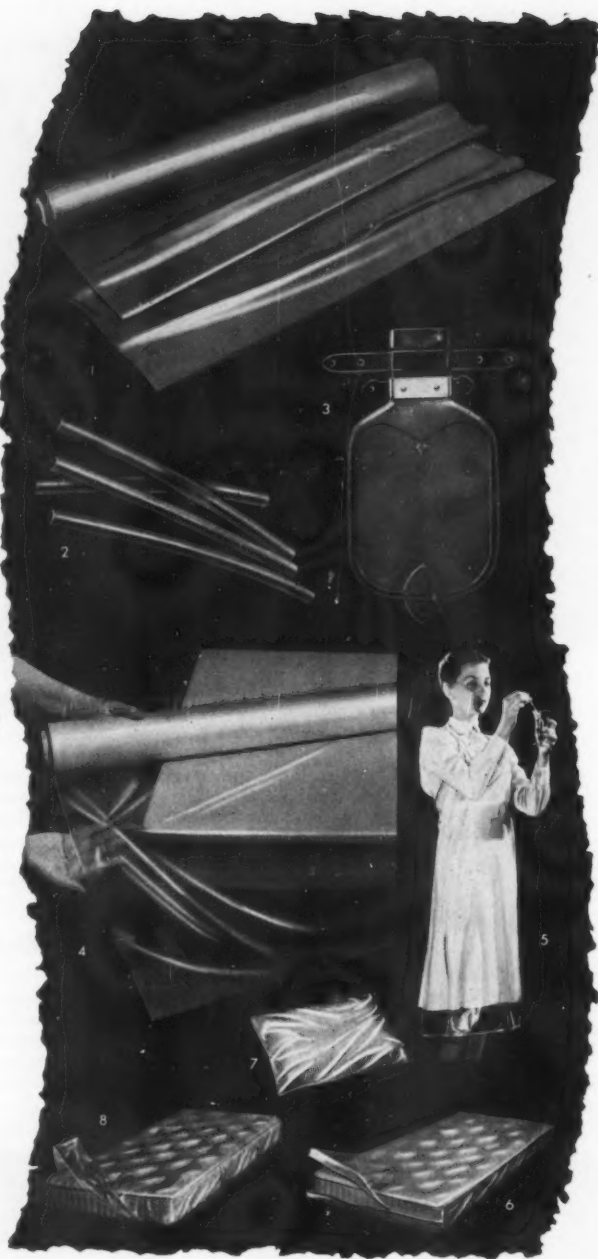
Keep these two Will Ross, Inc. trade marks in mind. "Aren" and "Arex" have acquired real significance in many hospital departments. They are the marks of products especially selected for service under conditions that, for one reason or another, are particularly demanding.

Take Aren Hospital Sheeting—a Koroseal product—for example. Koroseal has a reputation throughout the industrial world. Koroseal in many forms is accomplishing miracles, not alone in the hospital field but wherever tough, continuous and unusual performance is at a premium.

In making Aren Sheeting—a Koroseal product—available to hospitals, Will Ross, Inc. is performing a real service, for sheeting is an everyday necessity, in constant service. And it takes a healthy bite out of the hospital dollar. So this exceptional sheeting which gives so much for so little is important.

Not only in "Rubber" Goods, but wherever you meet these names "Aren" and "Arex" you can depend on them for something special in Quality, Service and Economy.

1. AREN hospital sheeting, a Koroseal product.
2. AREN brown latex drains.
3. AREN combination bottle.
4. AREX plastic film.
5. AREX plastic film bib apron.
6. AREX plastic film mattress cover.
7. AREX plastic film pillow cover.
8. AREX plastic film slip-over mattress cover.



Will Ross, Inc. Manufacturers and Distributors of Hospital and Sanatorium Equipment and Supplies
MILWAUKEE 12, WISCONSIN



the Westex...

FOR PRIVATE PRACTICE, CLINIC AND HOSPITAL The Westex, today's finest value in X-ray equipment, offers a complete range of radiographic and fluoroscopic techniques. The unit's features—separate floor-rail tube-stand, high flexibility, maneuverability, compactness—ensure maximum utility.

SINGLE TUBE • TWO TUBE • HAND ROCK • MOTOR DRIVE
Westinghouse representatives, solely concerned with X-ray equipment, will be pleased to consult with you; they are uniquely competent in analyzing needs, space, and budget requirements. For a conference and a fully informative booklet, call your representative or write to Westinghouse Electric Corporation, 2519 Wilkens Avenue, Baltimore 3, Md.

QUADROCONDEX • MONOFLEX • PTF • DUOFLEX • DUOCONDEX • SERVICE • ACCESSORIES

YOU CAN BE SURE...IF IT'S

Westinghouse

J-08201

MEDICAL X-RAY



moduline

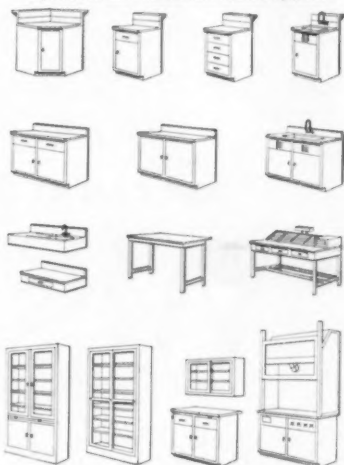
modern steel sectional furniture for hospitals and laboratories



The easiest and most economical way to install basic cabinets, casework, and fixtures in the modern hospital and laboratory

Moduline has made the planning and installation of hospital and laboratory fixed equipment an easy and comparatively low-cost problem. Moduline consists of a wide choice of standard drawer units, cabinets, sinks, work tables, etc., designed to make up a complete layout of basic equipment for laboratory, milk formula room, central supply, autopsy room; in fact, for any room where convenient, permanent work surfaces, storage spaces, utility connections and facilities are required. Steel sectional units are available 24, 35, or 47 inches wide, making it possible to plan large or small installations with a minimum of technical experience and labor costs. Line drawings at right show representative units which may be quickly arranged to form continuous, interrupted or island-type installations of any desired size. Sink units are available with basins of stainless steel or Alberene stone. Tops and splashbacks of all units are of stainless steel; body structures are of electrically welded steel. Our planning department is prepared to submit suggested room layouts and cost estimates for your Moduline equipment. Please write for descriptive brochure.

Representative units — Moduline steel sectional equipment



A. S. ALOE COMPANY

General Offices: 1831 Olive St., St. Louis 3, Mo.

Branches: Los Angeles, New Orleans, Kansas City, Minneapolis, Washington, D. C.

DIRECTOR OF DIETETICS AT HOUSTON'S HERMANN HOSPITAL REPORTS:



Mrs. Maude Sartor, Director of Dietetics at Houston's Hermann Hospital, checks food being prepared in Stainless Steel cooking vessels.

BECAUSE kitchen and cafeteria equipment of Stainless Steel requires so little upkeep and seemingly never wears out, its use is a great help to busy food department supervisors. It gives them more time for the important tasks of menu planning, food preparation and employee supervision.

Mrs. Maude Sartor, Director of Dietetics at Hermann Hospital, Houston, Tex., is thoroughly sold on these benefits of Stainless Steel. "Our Stainless equipment," she reports, "has been in service for two years without repairs, replacement or maintenance. What's more, it looks today as it did when it was installed."

Mrs. Sartor makes another point especially pertinent today, "Even though materials may be affected by shortages, you always know that if you have Stainless Steel, it's practically good for a lifetime. There's no 'hair-pulling' for replacement."

Ease of cleaning is another important advantage of Stainless equipment. Mrs. Sartor reports that a mild cleaning powder is the only cleansing agent needed to keep Stainless spotless and gleaming. Other types of equipment would require many kinds of cleaners and constant effort.

Now, with equipment replacements difficult, hospital administrators appreciate durable, corrosion-resistant Stainless equipment more than ever. Include Stainless in your plans for the future. And ask your fabricator to use perfected, service-tested U-S-S Stainless—it will give you the finest performance.

"With Stainless Steel equipment, we don't have to worry about maintenance, repairs or replacement."



Much Stainless equipment is concentrated in this area of the main kitchen at Hermann Hospital. It's been in service two years without a single repair or replacement.



After two years of use, the sparkling Stainless Steel equipment in the Patient Serving Room retains a "brand new" look.

Food serving facilities at Hermann Hospital designed by Ralph J. Mulhouser Co., Inc., Houston; fabricated by Southern Equipment Co., St. Louis, Mo.

AMERICAN STEEL & WIRE COMPANY, CLEVELAND • COLUMBIA STEEL COMPANY, SAN FRANCISCO
NATIONAL TUBE COMPANY, PITTSBURGH • TENNESSEE COAL, IRON & RAILROAD COMPANY, BIRMINGHAM • UNITED STATES STEEL COMPANY, PITTSBURGH
UNITED STATES STEEL SUPPLY COMPANY, WAREHOUSE DISTRIBUTORS, COAST-TO-COAST • UNITED STATES STEEL EXPORT COMPANY, NEW YORK



U-S-S STAINLESS STEEL

SHEETS • STRIP • PLATES • BARS • BILLETS • PIPE • TUBES • WIRE • SPECIAL SECTIONS

UNITED STATES STEEL



GOLEMON & ROLFE, ARCHITECTS

St. Frances Cabrini Hospital — Alexandria, La.
—an outstanding example of functional beauty
that can be achieved with Concrete
Joist Construction.

ALL OVER AMERICA, those responsible for building our hospitals are facing a challenging problem. Hospitals *must* be built *quickly*...yet materials and manpower are scarce. The need today is to make the *fullest* use of our total resources...of men...of material...yes, the most effective use of money, too! St. Frances Cabrini Hospital met the need by using *Ceco Meyer Steelform Concrete Joist*

Construction, which provides big savings these three ways:

1. SAVES MEN because less time and labor are required to provide open wood centering and form work.

2. SAVES MONEY by saving concrete... the "dead load" is kept to a minimum. Removable steelforms can be re-used, so only a small rental is charged.

3. SAVES MATERIAL because only a mini-

mum of critical steel is used. Less concrete is necessary than in other concrete floor constructions.

The result...a strong, flexible building capable of absorbing great strain. It's fire-resistive...SAFE; soundproof... QUIET. *Ceco*, originator of the Steelform method, is first in the field. So when concrete joist construction meets your need call on *Ceco*...the leader over all.

CECO STEEL PRODUCTS CORPORATION

General Offices: 5601 West 26th Street, Chicago 50, Illinois
Offices, warehouses and fabricating plants in principal cities

**CECO
STEEL**®

In construction products **CECO ENGINEERING** *makes the big difference*

for fast laundry drying

Leading Institutions rely on



HUEBSCH

open end
TUMBLERS

Cut
Laundry Overhead

Save Labor, Maintenance, Power, Fuel
Large Capacity
Quick, Easy Loading and Unloading

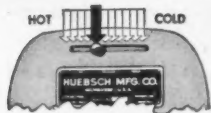
● When your laundry is equipped with Huebsch Tumblers, your costs for drying operations hit rock bottom. You're sure of getting faster drying at lower cost. For proof of Huebsch superiority, check the leading laundries and drycleaners who have bought more than 70,000 Huebsch Open-End Tumblers... more than all other makes combined!

You'll be amazed at how easily the Huebsch Tumbler takes the day-after-day punishment of drying capacity loads. It's built to last... to give you trouble-free service. It's compactly designed to save floor space... and make your operator's job easier and quicker.

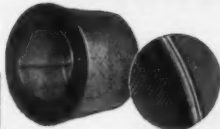
Every design feature has been proved practical. No fancy trimmings... no unnecessary panel housings to make maintenance difficult. Important parts such as the motor, reduction drive and coils are in the open so that they can be easily serviced.

When you invest in laundry drying equipment, be sure it's the best... HUEBSCH. See your Huebsch representative or write, wire or phone us.

MORE THAN 70,000 HUEBSCH TUMBLERS IN SERVICE
... Built better ... designed better by HUEBSCH



One-Lever Temperature Control provides complete range of temperature adjustments from hot to cold for faster, better drying.



Exclusive Huebsch "Spun-Lock" Cylinder construction insures a longer life of drying service.



Compact construction... Huebsch Tumblers, used individually or in a battery, cost less to run and maintain. Low initial cost.

FOUR SIZES

36" x 18"	36" x 30"
36" x 24"	42" x 42"

PRICES BEGIN AT

\$400⁰⁰

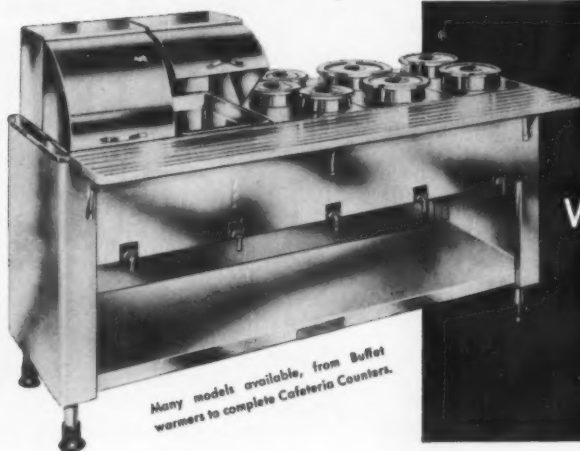
HUEBSCH
Originators

INVENTOR AND WORLD'S LARGEST MANUFACTURER OF OPEN-END DRYING TUMBLERS

Makers of the famous Huebsch Handkerchief Ironer and Fluffer • Pants Shaper
Automatic Valves • Feather Renovator • Double Sleeper • Collar Shaper
and Ironer • Garment Bagger • Cabinet and Garment Dryers • Washo-
meter • Hosiery Ironers • Spring-Type Filter.

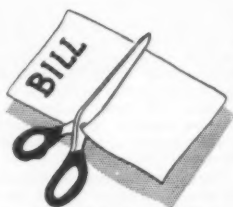
HUEBSCH MANUFACTURING COMPANY, 1770 N. 1st St., Milwaukee, Wis.

THURMADUKE

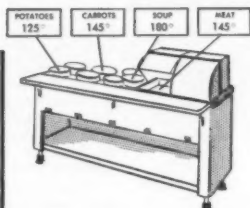


Many models available, from Buffet warmers to complete Cafeteria Counters.

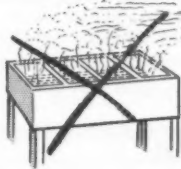
THE MODERN WATERLESS FOOD WARMER



Cut up to 70% off your fuel bill with waterless THURMADUKE.



Selective Heat Control keeps each food at proper temperature.



Waterless THURMADUKE operates without the unsanitary waterpan.



No steam to put an extra load on your air conditioner.

Surprising as it may seem, many otherwise modern food service establishments continue to keep food warm by methods not too different from those used by the ancient Romans.

"New" equipment of this same type is still being made today.

That's why it's important to you to be sure the new food warmer you buy is truly modern. Let your THURMADUKE Dealer explain the advantages of the modern waterless THURMADUKE; the importance of Selective Heat Control, of efficient insulation, of sharply reduced operating costs. We think you'll agree: No food service operation is completely modern without THURMADUKE.

See your THURMADUKE Dealer
or write for Catalog MH-7

DUKE MFG. CO., ST. LOUIS 6, MO.



**Good for
the patient.**

**Better for
the nurse**

**Best for the
hospital!**

Lily* Cups are good for the patient. They're quiet — no clatter or noise. They're easy to handle. The matched green leaf design makes an attractive tray set-up. And because paper is a natural insulator, Lily keeps foods and beverages hot — or cold — longer.

Better for the nurse. Serving trays are a joy to carry — They're so light — Lily saves time and labor — especially for supplementary nourishments or in tubercular or contagious disease wards. For "special diet" cases, Lily Cups come with snap-on lids on which name or room number can be written. Then, handy Lily Graduate Cups for medicines, cups for pills and for water are true nurses' aids.

Best for the hospital. Used only once, Lily Cups are always a safeguard against cross-contamination. They save labor — fewer people are needed to prepare meals or to clean up. No breakage, no dishwashing — savings in detergents, hot water and expensive equipment. And to speed meal preparation, many foods can be preportioned in Lily Cups.

Patient, nurse and hospital — all benefit with Lily Paper Service. We suggest you set up a tray — try Lily at breakfast, lunch or dinner. The necessary Lily Cups for a test will be sent you at once. Use coupon or write.

*T.M. Reg. U.S. Pat. Off.



LILY-TULIP CUP CORPORATION
122 E. 42nd Street
New York 17, New York
Chicago • Kansas City • Los Angeles
San Francisco • Seattle
Toronto, Canada

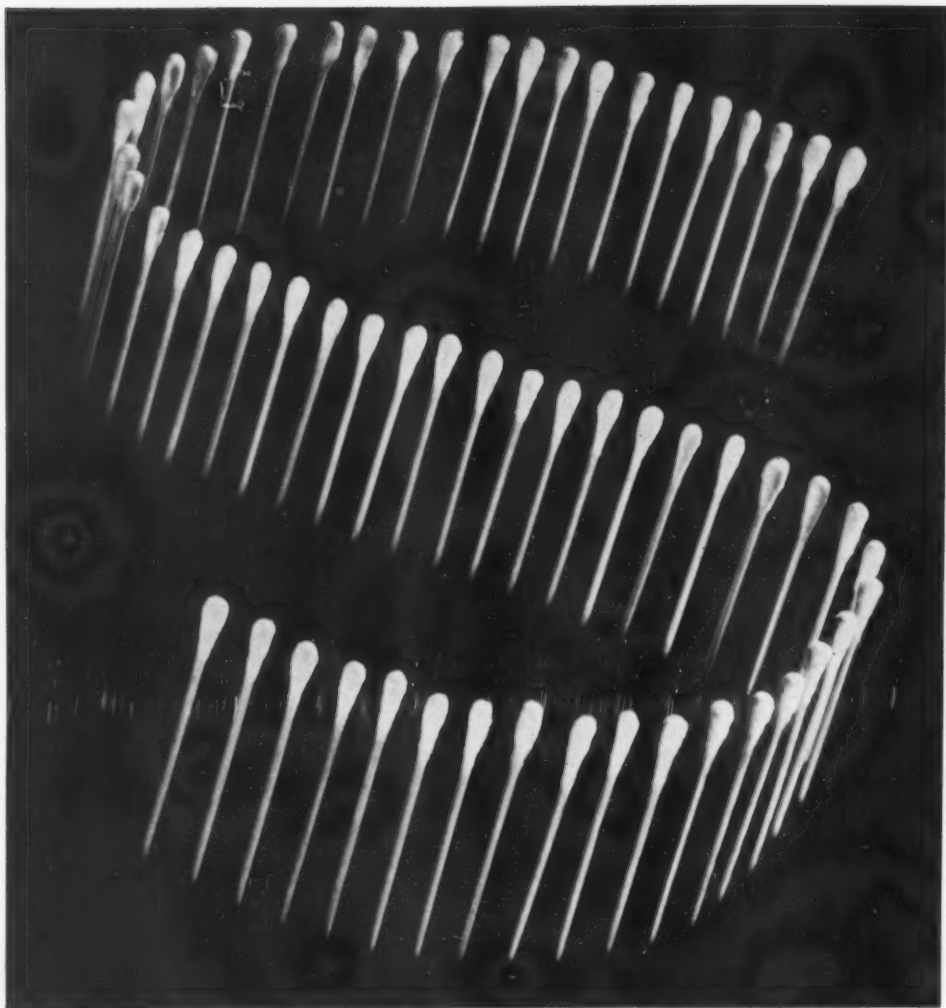
Lily-Tulip Cup Corporation, Dept. MH7
122 East 42nd Street
New York 17, New York

Please send samples and full information on Lily Hospital Cups.

Name.....

Street.....

City..... State.....



Glasco Machine-made Cotton-Tipped Applicators

YOU'LL NEVER GO BACK TO HAND WRAPPING

Once you have tried Glasco Machine-made Cotton-Tipped Applicators, you will never go back to time-wasting, costly hand wrapping.

For Glasco Cotton-Tipped Applicators will cost you less than the wood stick, the cotton, the labor—and the time

—of assembling old-style applicators.

Too, Glasco Cotton-Tipped Applicators are uniform, clean, tightly wrapped and come to you in sanitary envelopes with 100 in each so that applicators may be kept at every convenient spot.

Save time, labor and money. Use the

more sanitary, uniform and effective Glasco Cotton-Tipped Applicators.

Consult your Glasco Catalog, or ask your hospital supply salesman about lengths and size of wraps. Or write Glasco Products Company, 111 North Canal Street, Chicago 6, Illinois.

GLASCO PRODUCTS CO.

111 NORTH CANAL STREET, CHICAGO 6, ILLINOIS

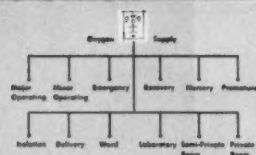
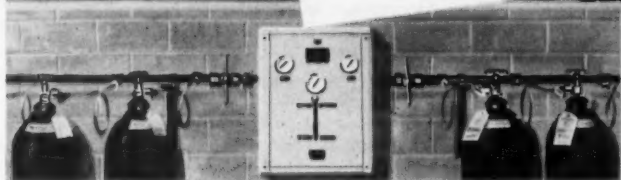
The MODERN HOSPITAL

NOTE TO HOSPITAL EXECUTIVES

This advertisement appeared in the June 18 issue of Time. We believe you will be interested in seeing it, for in addition to telling about NCG's products, it also serves to tell an influential segment of the public what hospitals all over the country are doing to improve the already fine service they render the public.



**INVISIBLE FORCE
TO FOIL
DEATH AND PAIN**



Important among the many modern treatments doctors are using to save life and relieve suffering is oxygen therapy. Its progress, in which NCG is playing an important part, has resulted in a growing trend in hospitals to central oxygen supply systems.

In this type of distribution, oxygen is piped through the hospital, as shown by the diagram at the right above, to neat, space saving wall outlets—as readily available, wherever needed, as electricity or running water.

A signal contribution to this evolution has been the new NCG "Even-flow" Control Unit, a spick-and-span, cabinet-enclosed, fool-proof mechanism for the central control of the flow of oxygen throughout such systems.

The "Even-flow" Unit is typical of the new energy, imagination and skill NCG has brought to the development of devices for the safer, more efficient, more convenient use of medical gases.

In addition to oxygen, NCG supplies anaesthetic gases such as nitrous oxide, cyclopropane, carbon dioxide, helium and various mixtures. Because NCG maintains a nationwide network of branches and authorized dealers, NCG can be relied upon for prompt and dependable service.

• • •

NCG's broad experience in the handling and application of compressed gases is rooted in 30 years of service to industry. In metal-working and scores of other in-

dustrial processes, NCG's numerous technical and supply services continuously provide ways for doing things faster, better, more easily and safely.

NATIONAL CYLINDER GAS COMPANY

Executive Offices
840 N. Michigan Ave., Chicago 11, Illinois
Copr. 1951, National Cylinder Gas Co.

NCG
MEDICAL SERVICES

HOW IMPORTANT IS THE SURGEON'S *Comfort?*



The surgeon reaches for a scalpel...he bends over the patient...the operation may last 2-3-4 hours. His freedom of movement and comfort are vital to the operation's success. Angelica operating gowns provide that comfort and freedom of movement...no binding, no looseness and completely capable of withstanding the punishment of long operations.

ANGELICA SURGEON GOWN...STYLE 606

- 1 Roomy raglan sleeves for freedom of movement.
- 2 Tunnel belt and reinforced yoke for greater comfort.
- 3 Absorbent snug-fitting double stockinette cuffs.
- 4 Overlapping back panels for greater sterility.
- 5 Full-cut, 54-inch finished length, full sweep.
- 6 "Green-Line" combed yarn bartacked tape ties.

Wide choice of exclusive Angelica fabrics, colors: jade green or white.

**Angelica Hospital Apparel Is Designed For
Maximum Comfort, Durability And Economy**

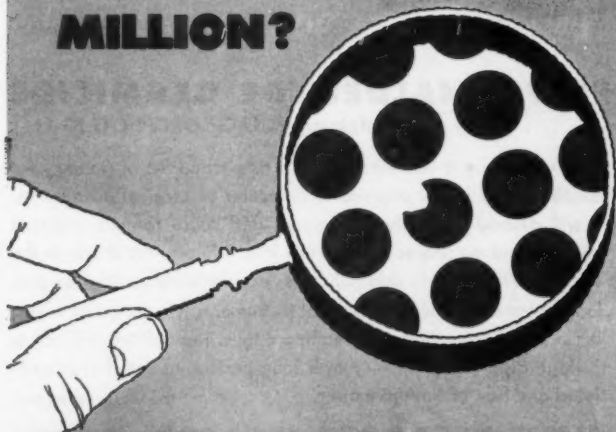
Angelica[®]
UNIFORM CO.

See your Angelica
representative
now

1427 Olive, St. Louis 3 177 N. Michigan, Chicago 1
107 W. 48th, New York 19 1101 S. Main, Los Angeles 15

CONSTANT RESEARCH MAKES ANGELICA FIRST IN HOSPITAL APPAREL DEVELOPMENT

**ONE
BAD ONE
IN A
MILLION?**



What looks like a solid blue background on this page is actually a "screen" made up of nearly a million little "dots". With a magnifying glass you could probably find quite a few defective dots in that million total.

But to the naked eye, the overall effect is satisfactory, so the bad ones can be tolerated.

You can rest assured, though, that

**THERE'S NOT EVEN ONE PART PER MILLION OF
HARMFUL ALDEHYDES IN THE U.S.I. PURE ALCOHOL
YOU USE IN YOUR HOSPITAL.**

In the U.S.I. test for aldehydes—more exacting than the one prescribed by U.S.P.—a special reagent is added to the alcohol sample. It causes a yellowish color to appear if even one part per million of aldehydes or fusel oil is present.

Rigid U.S.P. tests, plus a few more like the aldehyde test specially developed by U.S.I.—12 in all—assure you that U.S.I. Pure Alcohol is free from even traces of harmful impurities . . . is of known, uniform proof and quality. You can rely on U.S.I., the oldest producer of pure ethyl alcohol in America.

U. S. INDUSTRIAL CHEMICALS, INC., 60 EAST 42nd STREET, NEW YORK 17, N. Y.

U.S.I. PURE ALCOHOL U.S.P.

Partner in Medical Progress



when you specify

BARD-PARKER FORMALDEHYDE GERMICIDE

containing HEXACHLOROPHENE (G-11)*

• • • because it has established a new standard of potency for solutions used in the chemical disinfection of surgical instruments. It will destroy vegetative pathogens and spore formers within 5 minutes, and the spores themselves within 3 hours—as shown in the comparative chart. In addition, it is “economically usable” as prolonged immersion of delicate steel instruments will not result in rust or corrosive damage to keen cutting edges. The Solution will retain its high disinfecting potency over long periods of use if kept undiluted and free of foreign matter.

*Trademark of Sinder Corp.

PARKER, WHITE & HEYL, INC. • Danbury, Connecticut



For practical purposes we suggest the selection of B-P CONTAINERS—all scientifically designed for use with the Solution.



Compare this significant data evaluating the potency of the IMPROVED germicide

SPORULATING BACTERIA	10% DILUTED BLOOD	WITHOUT BLOOD
<i>C. tetani</i>	3 hours	3 hours
<i>C. welchii</i>	2 hours	2 hours
<i>B. anthracis</i>	1½ hours	1½ hours
VEGETATIVE BACTERIA		
<i>Staph. aureus</i>	5 min.	15 sec.
<i>E. coli</i>	3 min.	15 sec.
<i>Strept. hemolyticus</i>	2 min.	15 sec.

Ask your
dealer

For detailed information see our Catalog in 1951 HOSPITAL PURCHASING FILE

for surgeons who like cotton

*eliminates the
disadvantages
of ordinary
commercial
cotton*

*Davis & Geck
cotton*

1. Unsurpassed tensile strength in all diameters permits use of smaller sizes.
2. "Cotton sawing" or "tissue drag" has been eliminated. Trauma is markedly reduced by the smooth surface of this new cotton.
3. Tightly twisted strands, free of fuzz, allow easy threading and firm knots.
4. U.S.P. sizes—D&G surgical cotton conforms to U.S.P. gauge standards; commercial cotton varies considerably.
5. Repeated sterilization is now possible. Davis & Geck's new cotton may be boiled or autoclaved 12 times.
6. Economy results from greater tensile strength and repeated sterilization.

*Table of
equivalent
sizes*

Ordinary Cotton commercial sizes	Surgical Cotton U.S.P. XIV sizes
90-100	5-0
40-50	4-0
30-40	000
18-30	00
12-18	0
10-12	1

surgeons agree on D&G

Packaging: Spools of 100 yards, size 5-0 to 2 and in tubes sizes 4-0 to 1. Many available with Atraumatic® brand needles attached.

Davis & Geck, Inc.

A UNIT OF *AMERICAN Cyanamid COMPANY*

57 Willoughby Street



Brooklyn 1, N. Y.



from "intractable" asthma

The unique blocking action of ACTHAR against complex manifestations of hypersensitivity has been well-established. For the patient with severe, intractable asthma, ACTHAR produces most gratifying results; the threat of asthmatic attacks can be minimized.

Status asthmaticus which has defied all other therapeutic attempts may yield quickly to relatively small doses of ACTHAR.

Definite and often dramatic improvement of the patient makes ACTHAR therapy a truly economic measure in the difficult management of severe asthma.

ACTHAR Dosage.—*Initial Dose:* Less severe cases, 12.5 mg. q. 6 h. Severe, chronic cases, including status asthmaticus, may require up to 25 mg. q. 6 h. The initial dose should be continued from 2 to 4 days or longer in severe cases. *Tapering of Dose:* When symptoms have been controlled, decrease dosage 5 mg. per injection every other day until a total of 10 to 12 days of therapy has been given. *Maintenance Therapy:* May be required in severe, chronic asthma; 10 to 20 mg. once or twice per day.

Literature and directions for administration of ACTHAR, including contraindications, available on request.

ACTHAR is available in vials of 10, 15, 25 and 40 I.U. (mg.). The Armour Standard of ACTHAR is now accepted as the International Unit; 1 International Unit is identical with 1 milligram of ACTHAR.

ACTHAR



THE ARMOUR LABORATORIES

CHICAGO 11, ILLINOIS

PHYSIOLOGIC THERAPEUTICS THROUGH BIORESEARCH

Modern Xavier Hospital relies on Modern *GAS* Cooking



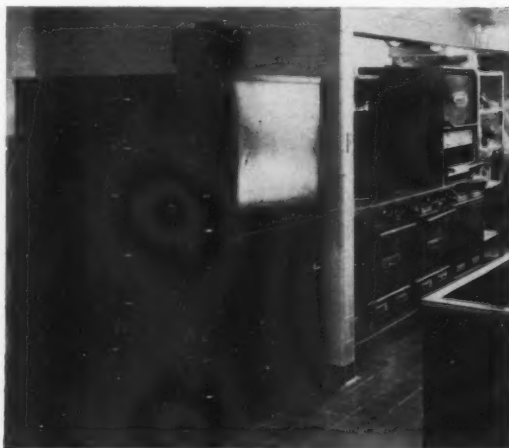
THE HOSPITAL: Xavier Hospital in Dubuque, Iowa, is a modern 100-bed establishment under the direction of Sister Mary Marcellus, O.S.F., Superior and Superintendent.

THE COOKING TASK: 500 meals a day must be prepared for patients and members of the hospital staff. Not only must regular meals be cooked quickly and appetizingly, but special diets must be catered to at the same time. All pies, cakes, bread and pastries are baked at the hospital too.

THE COOKING EQUIPMENT: To prepare 500 meals a day, the hospital uses the following Modern Gas Equipment in its compact, efficient Gas kitchen: Blodgett Gas Oven; Vulcan Gas Range unit composed of 2 hot tops; French Fryer; Broiler.

THE GAS COOKING FACTS: Cooking with Blue Flame GAS saves work. Automatic GAS Temperature Controls save time, effort and work for the Xavier Hospital kitchen employees. Gas gives the cooking and baking temperatures they want when they need them . . . fast.

HOW GAS COOKING CAN SERVE YOU: Blue Flame Gas cooking is clean. Gas is dependable, efficient, and economical. Modern Gas Equipment is the answer to modern cooking problems. Call your Gas Company Representative today. He will show you the values of using Modern Gas Equipment in your kitchen.



MORE AND MORE...

THE TREND IS TO GAS

FOR ALL
COMMERCIAL COOKING

AMERICAN GAS ASSOCIATION

420 LEXINGTON AVENUE, NEW YORK 17, N. Y.

LEADERSHIP IN SALES!



Your Best Proof of GARLAND QUALITY



MODEL NO. 83 GARLAND RESTAURANT RANGE—Six open top burners, griddle, broiler and two ovens. Choice of top sections to give exact arrangement of open grate, hot top and griddle sections you need. Also three other basic restaurant range models; each with choice of top sections.

MODEL NO. 38 GARLAND DINETTE—Sensational value! Features include: large broiler, ample storage space, full size oven, four open top burners, large griddle, convenient drip pans. With or without high shelf. Standard finish is BLACK PORCELAIN. Also available in stainless steel.



When one line of commercial cooking equipment far outsells all others, year after year, *there are good reasons!* Always one reason is *quality!*

It is Garland quality which enables Garland to *out-perform* and *out-economize* the field. And Garland production, by far the largest in the industry, gives indisputable proof that Garland *out-values* the field!

For the best quality and the best buy in restaurant ranges — see your Garland dealer.

All Garland units are available in stainless steel and equipped for use with manufactured, natural or L-P gases.

GARLAND*

THE TREND IS TO GAS

FOR ALL
COMMERCIAL COOKING

Heavy Duty Ranges • Restaurant Ranges • Dinette Ranges • Broilers • Deep Fat Fryers
Toasters • Roasting Ovens • Griddles • Counter Griddles

DETROIT-MICHIGAN STOVE CO.

REG. U.S. PAT. OFF.

Detroit 31, Michigan • Fine Ranges Since 1864



ACCIDENTS CAN HAPPEN in Hospitals, too

... so Doors should be Weldwood

Even in the *best* regulated hospitals, accidents happen. And when they happen to *doors*, you'll be glad that they're WELDWOOD!

Weldwood Flush Doors can certainly *take it*. That's being proved in hospitals every day—and *night*.

And Weldwood's beautiful hardwood faces are as easy to look at as a pretty nurse. They lend a quiet, relaxing atmosphere to a corridor, too.

They have perfect balance... are easy to open and close. *Guaranteed* not to stick or warp.

And here's another important thing to remember. The incombustible mineral core of these Weldwood doors provides an *unusually high* margin of safety from fire.

For every reason you can think of, specify Weldwood Doors!

THE WELDWOOD® FIRE DOOR carries the Underwriters' Label for all Class B and C openings. Has incombustible Kaylo® core with special construction and fireproofed edge banding. Standard flush faces are handsome birch veneers. Wide variety of other fine hardwood faces available on special order. Safe. Beautiful. Maximum durability. Dimensionally stable.

THE WELDWOOD STAY-STRATE DOOR is similar to the Weldwood Fire Door but the edge banding is not fireproofed. Recommended for use where a labeled door is not specified, but where fire resistance is a desirable advantage. Same wide variety of beautiful hardwood facings.

*Reg. Trademark, Owens-Illinois Glass Co.

United States Plywood Corporation carries the most complete line of flush doors on the market including the famous Weldwood Fire Doors, Weldwood Stay-Strate Doors, Weldwood Honeycomb Doors, Mengel Hollow-Core Doors, Mengel and Algoma Lumber Core Doors, 1½" and 1¾" with a variety of both foreign and domestic face veneers.

WELDWOOD FLUSH DOORS

Manufactured and distributed by

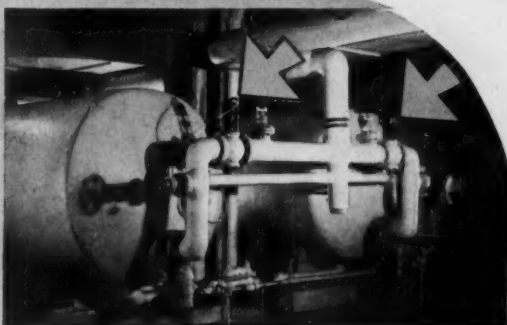
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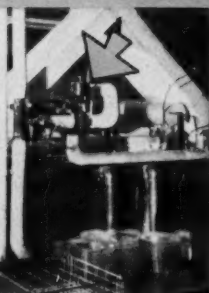
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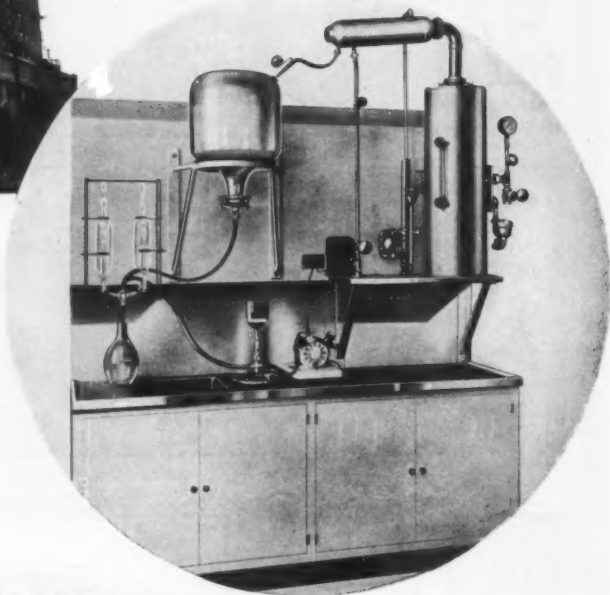
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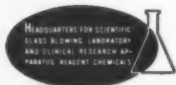
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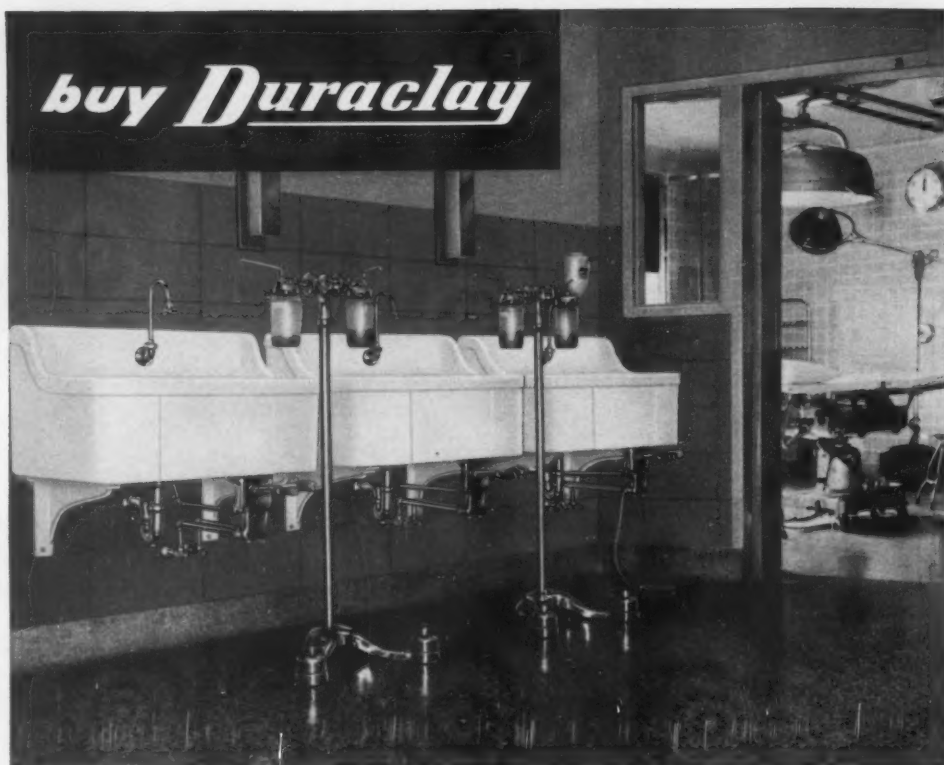
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Small Hospital Questions

Should Doctors Be Trustees?

Question: Should we have one of the doctors on the board of trustees of our hospital?—A.K., Calif.

ANSWER: A great deal has been said and written over the last 15 years on the subject of whether or not practicing doctors in any hospital should be voting members of the board of trustees of that institution. The American College of Surgeons, the American Hospital Association and the American College of Hospital Administrators all advise against having any doctor who is in active practice as a voting member of a hospital board of trustees. There are many reasons for this. Among the most important reasons are:

Any doctor on the board of trustees has an advantage over all other members of the staff. Being a member of the board gives him a preferential position and also gives him an advantage insofar as the general public is concerned. So many instances where this has caused trouble have been brought to light that it seems sound practice not to have doctors as board members.

Then, too, there is a legal problem involved which several experts in hospital and medical law have been discussing lately. It is the legal and moral responsibility of the board of trustees to use due care and discretion in making hospital staff appointments. How can a doctor sitting as a voting member of the board of trustees be disinterested in passing on his own qualifications to be a member of the staff?

There are many excellent methods of getting the doctors into the general affairs of the hospital without having them as voting members of the board. For instance, the doctors themselves can, through a medical board appointed by the board of trustees, work regularly with the hospital administrator and the trustees in every problem involving the hospital.

The medical board usually consists of the chiefs of the various clinical and laboratory services, plus the elected president and secretary of the organized staff. In this connection it is important that the radiologist and pathologist be considered as chiefs of major departments and be made members of the so-called medical board.—E. W. JONES.

Shoes for Safety

Question: Our institution is a 66 bed general hospital, plus 20 bassinets. We do not have a segregated obstetrical division. The maternity patients are on the same floor as the clean surgical and medical cases. The delivery room and labor room are in the same suite with the operating room. The floor nurses have to attend the patients during labor and delivery. We have ordered a machine for the administration of anesthetic gases. We know that the floors will have to be made nonconductive, and other measures will have to be taken to make the department safe.

However, we have a problem and that is the question of shoes and nylon uniforms. Several of the staff nurses have nylon uniforms. They also come to us from other hospitals with nylon uniforms. Because of the expense, they are unwilling to purchase cotton uniforms as they are either more expensive or are difficult to launder. At one time, the state fire marshal stated that nylon uniforms should not be worn. No rule was made, and I know that several hospitals in the same situation as we are permitting the nylon uniforms to be worn. Is it necessary for everyone who enters the suite to wear nonconductive shoes? What are other hospitals doing to solve this problem?—R.M.S., Wis.

ANSWER: No one working in any anesthetizing location should at any time wear outer garments or hosiery made from silk or any of the synthetic textile materials, such as rayon or nylon, including sharkskin. This statement is from Item 13-7 on page 25 of the National Fire Protective Association Bulletin No. 56 on recommended safe practice for hospital operating rooms. This bulletin was approved by the National Fire Protective Association, the National Board of Fire Underwriters, and the American Hospital Association.

Several companies make conductive flooring that meets the requirements of

the National Fire Protective Association's code for hospital operating rooms. These materials can be applied over old floors. It will pay to investigate them carefully.

With reference to the question, "Is it necessary for everyone who enters the suite to wear nonconductive shoes?" the reverse is the case. Everyone working in the operating room during the progress of an operation where an anesthetic is being given should definitely wear conductive shoes.

Shorter Hours for Nurses

Question: In this hospital of 90 bed capacity, we have a staff of 65 graduate nurses and in addition we have registered on our list some 50 private duty nurses. When a private duty nurse is registered, she is called upon to perform a 12 hour duty. Recently we have had a petition from a number of private duty nurses to reduce the 12 hour duty to an eight-hour duty at the same fee. In support of their request these nurses referred to the procedure followed in the United States, adding that not only there but in other progressive countries there is no such thing as a 12 hour duty. We look at this matter from the doctors' and patients' standpoint chiefly, as it would be very costly for the patient to pay the cost of three private duty nurses as well as the meals taken by them. Moreover, if we accede to their request of an eight-hour duty, our own staff nurses would immediately leave us and seek private duty work.—W.A., Mexico.

ANSWER: I agree with the private duty nurses that there is no longer any excuse in this day and age for 12 hour duty. It is my impression that 12 hour duty private nursing has not been done in the United States for quite a number of years.

All the hospitals in this country had the same problem you describe and they did not experience any great loss of general staff nurses who deserted to go to private duty nursing. After all, the private duty nurse doesn't have as steady employment as does the general staff nurse. By and large, in this country she ends up the year with no more money than and often not as much as does the general staff nurse.

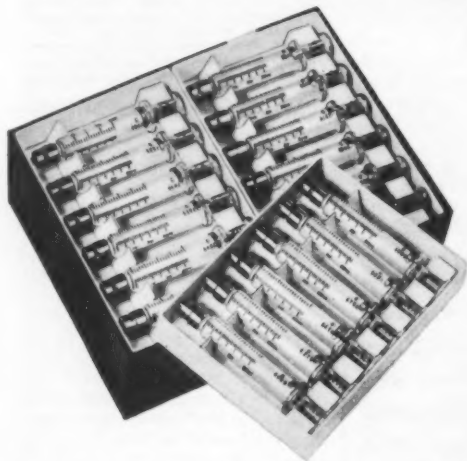
Of course, hours of duty, conditions of work, high grade and intelligent supervision, good educational programs, and adequate salaries commensurate with other types of employment are always "musts" if general staff nurses are to be kept satisfied.—E. W. JONES.

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wire from **Washington**

NEWS OF THE MONTH

For the first time since start of the Korean war, hospital administrators should now be able to get the information they need out of Washington without too much delay. Furthermore, the administration has released the basic details of a hospitalization-for-the-aged program which, even though it may never become a law, is certain to figure in future political campaigns for years to come.

As the log-jam broke loose, these were the major developments:

1. Federal Security Agency officials, who had been working quietly on the project for many months, passed out for publication the outline of the new plan for hospitalizing the aged.

2. The question of who should represent civilians as "claimant" for scarce hospital and medical supplies was settled in favor of Public Health Service's Division of Civilian Health Requirements.

3. Defense Production Administration announced that sufficient quantities of scarce materials would be set aside for hospital construction in the third quarter, when the controlled materials plan became effective.

4. Senate went along with House in approving sufficient money for Hill-Burton construction to maintain the program at about its current level.

HOSPITALIZATION FOR THE AGED

The plan worked out by Federal Security Agency officials, a group of labor leaders, and certain other officials in the health fields calls for government-paid hospitalization of persons 65 and over who are covered by social security. There would be a limit on the amount of hospital service allowed each year (possibly two months), medical costs would not be included, and hospitals would not be required to accept such cases if their beds were occupied by other patients.

To be eligible, a person would not have to be receiving social security benefits, but merely be eligible for them. Thus an elderly patient could be admitted to a hospital, with his bill paid by the federal government, regardless of his wages or other income. It is estimated that between 5,000,000 and 7,000,000 persons would be eligible now.

There is a possibility that President Truman will make this program the subject of a special message to Congress prior to the planned summer recess. At any rate, persons familiar with the strategy say that the issue will be made an important one in the administration's campaigning in 1952.

No official estimate has been made of the costs, but the assumption is that they will be met by an increase in social security payments. One insurance official estimated that policies insuring elderly persons for the hospital benefits listed above would cost between \$100 and \$150 a year.

ALLOCATION OF HOSPITAL SUPPLIES

For several months hospitals have had a choice of agencies to appeal to for help in getting scarce materials for construction, operation and maintenance: (1) the Office of Civilian Requirements of National Production Authority or (2) the Division of Civilian Health Requirements in Public Health Service. Both organizations have invited inquiries, both have attempted to carry on the same sort of program.

From now on only the Public Health Service division will operate in this field, on orders of the Defense Production Administration.

D.P.A. ruled that it would have primary responsibility for drawing up the estimated requirements "... (which) will then be submitted to D.P.A.'s Office of Program Requirements, there to be matched against estimates of the total supply of the materials that will be available for use. . . ."

As a routine responsibility, the P.H.S. division will keep Defense Production Administration informed of future needs for hospital and medical supplies by all civilian users, with the exception of Veterans Administration. Individual hospitals having supply difficulties should contact Charles G. Lavin, Chief, Division of Civilian Health Requirements, Office of Surgeon General, Public Health Service, Washington 25, D.C.

American Hospital Association has taken leadership in a movement to simplify the problems of allocating hospital and medical supplies. Without getting into the encumbering "initial organizations" involved, it would provide for a voluntary advisory committee made up of representatives of the ultimate users, such as the nongovernment groups, Veterans Administration, Economic Cooperation Administration and the military services. Members of this committee would sit down periodically and attempt to get their future requirements in line with future production. The committee then would pass on its decisions to Defense Production Administration, which under the law is responsible for distributing scarce materials.

At present, each section of the consuming market, such as V.A., E.C.A. and the military, acts independently of the others in filing future requirement schedules. If the plan is adopted, and it probably will be, the consuming groups will settle their own arguments and not wait for arbitrary decisions to be handed down from above. All groups concerned agreed on the basic plan at a Washington meeting called by American Hospital Association. Present also were representatives of pharmaceutical and surgical producers.

MATERIAL SET-ASIDE PROGRAM

Another Defense Production Administration action ensures that hospitals and clinics, along with schools, will be assured necessary amounts of scarce materials for construction during the current third quarter. Ordered set aside

for use during July, August and September are 75,000 tons of carbon steel, 950,000 pounds of stainless steel, 4,600,000 pounds of copper and copper base alloy, 550,000 pounds of aluminum. Institutions have access to set-aside supplies through a special preference rating. Up to now materials have been allocated on a month-to-month basis, but the new plan is expected to make possible a more precise estimate. (A reminder: no hospital construction may be started without special authorization if more than 25 tons of steel are to be used; application through Division of Civilian Health Requirements, P.H.S.)

CONTROL AND SUPPLY NOTES

Hospitals using DO-97's are being allowed to use 120 per cent of the base period in dollar value, because of increasing costs. The estimate is that the extra 20 per cent will not mean more supplies. . . . Criteria for issuing hospital construction permits are (1) essentiality, (2) timeliness and (3) changes that will favor use of nonscarce materials.

Effective now, and probably until the first of the year, hospitals will send their combined construction-allocation applications directly to Division of Civilian Health Requirements, P.H.S., in Washington. The plan now is to work out a system for decentralizing these authorizations, but the machinery probably will not be ready for five or six months. Application forms (4C) may be obtained from state hospital officials. P.H.S. officials say manufacturers of hospital equipment will not necessarily be seriously affected by the newest iron-steel-copper-aluminum cutback order (M47-A). Section VII of the order exempts materials covered by allotments, including all essentials for hospital construction and maintenance. However, to ensure adequate set-asides, hospitals in the planning or construction stage are urged to file their 4C forms immediately.

Office of Price Stabilization is watching the beef supply of hospitals but is unlikely to take action except as a part of a general extension of controls. This means that individual hospitals having trouble getting beef can expect no help from Washington unless the situation becomes much worse.

OPPOSE 'HOOVER PLAN'

The Hoover Commission's long dormant program for a federal department of health again is stirring up more than a ripple of interest. The idea, embodied in S. 1140, would place virtually all government health services, hospitals included, under a new, cabinet-rank department. The major exception would be overseas military hospitals. When the Senate committee on expenditures in the executive departments indicated it might act on the bill, almost every government department to be affected quickly got in a word of protest. The Bureau of the Budget (an executive office) opposed it because it runs contrary to the President's plan for a department of health, education and security. Furthermore, said Director Frederick J. Lawton, "there is the danger that the proposed Department of Health would be so preoccupied with its vast hospital programs that public health and preventive medicine activities would not receive the attention which their importance merits."

F.S.A. Administrator Oscar Ewing opposed it for about the same reasons, also because "medical research, preven-

tive medicine, grants-in-aid, and health education—activities which now constitute a principal function of the Public Health Service—inevitably would be dwarfed and subordinated, and suffer loss of emphasis and prestige." V.A. Administrator Carl R. Gray filed a strong statement of opposition, emphasizing that: "The proposal runs counter to the historic policy of our government to treat its veterans as a class deserving of special consideration, through one agency charged with the responsibility, to the extent possible, of administering all of their various benefit programs." Army Secretary Frank Pace endorsed the objections of the governor of the Panama Canal, whose civilian hospitals would be placed under the proposed new department. Defense Department opposed it because the bill "would seriously affect the incentive or desire of doctors, dentists and nurses for a career in the armed services. . . . The training of medical and dental officers and nurses and enlisted personnel in medical research and preventive medicine would of necessity be so limited as to be of little value."

Outside Washington, sponsors of the bill were active. A group of 21 physicians, members of the national advisory board of the Doctors Committee for Improved Federal Medical Services, sent the committee an imposing list of reasons why the bill should be passed. They reminded the senators that the Hoover Commission had discovered that five major and 30 smaller government agencies were carrying out uncoordinated medical programs. The result, the doctors said, is "competition for doctors, nurses and technicians, wasted hospital facilities, unjustifiable expense to the citizen and very often inferior services to beneficiaries."

CLARK REPORT

The Dean Clark report on voluntary health insurance, loaded with facts and almost devoid of editorial opinion, already has become somewhat of a textbook on the subject. With completion of the 10 month study, 10,000 copies were ordered by the Senate health subcommittee, and immediately plans were made for a second printing. The committee hopes to continue to distribute the document without cost. Some of the more important findings include:

1. Half the people of the country have no hospital, medical or surgical coverage of any sort. The other half have at least some form of hospitalization; in addition, 42 per cent of this "insured" group also have some surgical protection, 22 per cent have varying amounts of medical as well as surgical and hospital coverage, and 6 per cent have comprehensive care insurance, including hospital, surgical and relatively complete medical insurance.

2. In 1949 (the year studied) insurance benefits paid for about one-fourth of all private hospital care expenditures, but only one-tenth of the expenditures for physicians' services.

3. Only a small fraction of the public is protected against dental care costs, nursing, laboratory or other diagnostic tests (except in the hospital) or the cost of drugs and special treatments or devices.

The report makes no recommendations at all on such bitterly controversial subjects as a national compulsory health insurance program. On these questions it merely condenses the main arguments on both sides. However, Dr. Clark strongly urges that Congress provide for a continuing, aggressive study of the problems of health insurance. He suggests that the health subcommittee itself coordinate the work of private and governmental agencies in this field.



Looking Forward

Great New Market

VISITED friend in hospital last week," Anastasia remarked during one of her random tours of the office a few days ago. "Better he should be sick in a nice, quiet boiler factory," she went on. We asked how come.

"Four different radios going like mad," Anastasia explained, "—Rossini, dance band, comic, 'see our cars before you buy.' Traffic in hall like Times Square Saturday night. Visitors, nurses, patients, doctors, orderlies, vagrants. All talking to deaf friends."

We acknowledged that hospital noise can easily get out of hand and offered to remind administrators to renew their efforts to control it.

"Wouldn't do it if I were you," Anastasia replied, surprisingly. "Cut off great new market your advertising department."

"Soundproofing?" we asked as she got ready to go. Anastasia shook her head.

"Earmuffs," she said.

Short Course

IN RESPONSE to numerous requests, the Public Health Service, Division of Medical and Hospital Resources, has prepared an outline of an organization plan and curriculum for an institute designed to present the essential facts and relationships of hospital organization and management to interested groups in the community planning a new hospital. In somewhat abridged form, the outline will be published in this issue (page 65) and a succeeding issue of *THE MODERN HOSPITAL*.

Carefully developed from Public Health Service experience demonstrating the interests and needs of groups planning new hospitals, the outline is certain to be helpful to those concerned with building, staffing and operating these institutions. In addition, however, it includes a wealth of information and ideas for those who are responsible for planning institute, convention and conference programs for hospital associations and councils. It should also be helpful to administrators plan-

ning educational programs for hospital trustees and auxiliary groups. As a matter of fact, the outline represents a short course in hospital organization on which most administrators themselves could well afford to spend a few hours.

Hospital-Medical Conferences

DURING the discussions that preceded action on the joint hospital accreditation plan by the house of delegates of the American Medical Association, trustees of the A.M.A. referred several times to the invitation they had received from officials of the American Hospital Association to meet together for discussion of hospital-physician problems. Obviously, A.M.A. and A.H.A. officers are counting on these conferences to resolve misunderstandings and point the way to better hospital-medical relations—a circumstance which should certainly make it easier for hospitals and their staffs to find reasonable answers to their individual disagreements.

As the standardization conferences which have already been held amply demonstrated, an extended exchange of views among responsible people can result in satisfactory negotiation of even the most complicated and embattled differences. At the recent A.M.A. meeting it was significant that the hospital interest in standardization was ably explained and defended throughout the long and often controversial discussions, not by hospital people but by A.M.A. trustees who had taken part in the standardization conferences and thus gained in understanding of hospital problems and interests.

The American Hospital Association was wise to take the initiative in suggesting continued A.H.A.-A.M.A. conferences, which will no doubt deal with such knotty problems as the financial arrangements between hospitals and medical specialists and control of surgery. Obviously there is no easy answer to these problems, and no amount of discussion is going to develop a formula which can be used by hospitals and doctors everywhere to solve their difficulties. What the con-

ferences can do is help to clear up whatever part of the hospital-physician conflict is caused by misunderstandings of fact and misapprehensions of the intentions of disputing groups and individuals. As it did in the hospital standardization discussions, however, that may accomplish a lot.

Tale of Two States

ANY proposition which asserts that the medical profession or organized medicine thinks or acts as a unit is likely to be inaccurate, if not downright false. Like the public itself, the profession is a complex of groups representing all shades of thought and opinion on all subjects, and the groups themselves are complexes of subgroups and individuals representing even wider variations.

As evidence that this is true on a major scale, the following circumstance is offered: While the Iowa State Medical Society was knocking itself out last month approving a ruling of the state board of medical examiners that resident physicians must be licensed, thus effectively barring graduates of foreign medical schools from residency appointments in Iowa hospitals, the New Jersey State Medical Society was knocking itself out to get visas and find jobs in New Jersey hospitals for graduates of German medical schools seeking residency appointments to complete their education in this country. An official of the Iowa society defended its action on the ground that "We do not want Iowa to become a dumping ground for foreign physicians." An official of the New Jersey society explained its action on the ground that "We want these foreign physicians to benefit from the experience of medical study in a democratic society."

Good Idea

AS REPORTED elsewhere in this issue, the American Medical Association has announced the forthcoming appointment of a lay advisory committee representing industry, labor, agriculture, education, the law and the clergy. Purpose of the committee will be to advise the association in matters of medical care and to present the viewpoint of the general public, it was announced. "Men and women who serve on the committee will be divorced from politics and will be serving unselfishly for the betterment of health and medical care for all the people," said Dr. Louis H. Bauer, president-elect of the A.M.A.

It is hard to imagine how a professional association could take a more constructive step toward building better public relations than this one which takes the public into its confidence, so to speak, and asks for help. Too often, the public relations efforts of such special interest groups consist wholly of public pronouncements insisting that everything is wonderful and anybody who says different is a leftist, if not actually a Communist. The appointment of a lay advisory committee is wholesome evidence that the association is taking the problem-solving rather than the problem-denying approach. That

fact by itself should win more real public support than the most turgid pronouncement of virtue.

In effect, the American Hospital Association took the same sound approach several years ago when it organized the Commission on Hospital Care. The commission was charged with the single responsibility of analyzing the adequacy of the nation's hospital facilities; once that was done, its activities were terminated. As the A.M.A. plans to do, it might be a good idea now for the A.H.A. to revive the commission or its equivalent as a continuing advisory group representing the interests of the general public. As a matter of fact, it wouldn't do any harm for the two groups to meet together once in a while.

Will Ross

THE entire hospital field was saddened last month by the death of Will Ross, for many years one of its most respected and beloved figures. Familiar to most hospital people is the story of how Will Ross became interested in hospitals when he was a patient in a tuberculosis sanatorium and how, while he was conquering his own disease, he built that beginning interest into a nationwide business serving hospitals. Less familiar are the stories of his personal relationships—the many men and women in his own organization, in hospitals, and in related fields whom he helped and inspired in their personal and professional lives. Least familiar is the story of his final illness—the months of suffering during which he carried on his work, his condition unknown to all but a few friends and associates.

Unquestionably, Will Ross contributed measurably to the improvement of hospital care in the United States. There are few better ways to be remembered in this world.

Back Door Caller?

FOR the last two or three years, everybody who spoke up against expansion of the Veterans Administration hospital system was noisily shouted down as unpatriotic, if not downright subversive. At various times, the Hoover Commission, the American Hospital Association, The MODERN HOSPITAL and others felt the hard boot of public disfavor propelled by loud-voiced congressmen, veterans' organizations and their lobbies.

Now come reports of nice new V.A. hospitals that are finished but not opened for lack of staff, and community hospitals crippled by loss of nurses and other workers who have vanished into the comparative prosperity of V.A. employment. These are eventualities that were foreseen by the interested observers whose warnings were ignored. It is conceivable now that under the stress of national emergency doctors and others could be drafted for service in V.A. as well as military hospitals. While we were barricading the front gate against the threat of compulsory health insurance, socialized medicine may have been walking in the back door unnoticed—in a soldier suit.

The three presidents: Dr. John W. Cline of San Francisco, now president (left), Dr. Elmer Henderson of Louisville, Ky., immediate past president (center), and Dr. Louis H. Bauer of Hempstead, N.Y., chosen as president-elect.



A.M.A. APPROVES JOINT ACCREDITATION

*But delegates express misgivings, urge A.M.A. trustees
to seek increased medical representation on joint board*

ATLANTIC CITY, N.J.—At its annual meeting here last month the American Medical Association approved participation in the proposed joint commission on hospital accreditation in cooperation with the American Hospital Association, American College of Surgeons, and American College of Physicians. However, delegates expressed some misgivings about the adequacy of A.M.A. representation on the commission and urged trustees to proceed "by an evolutionary process" from the 6-6-3-3 representation plan embodied in the present proposals to a suggested 8-4-3-3 arrangement under which, many delegates felt, medical interest in professional standards in hospitals would be more adequately protected.

The house of delegates also recom-

mended establishment of an advisory committee to the accreditation commission representing all the scientific sections of the A.M.A. Members of the advisory committee should be permitted to observe the deliberations of the commission, it was suggested. While some delegates were plainly apprehensive about details of the proposed commission's operations, action by the house left the trustees free to effect A.M.A. participation in the commission on the basis of the present proposals and work toward the suggested modifications as they saw fit.

With A.M.A. cooperation thus assured and with action approving the joint commission already taken by regents of the American College of Surgeons and American College of Physicians, it remained only for the pro-

gram to be approved by the house of delegates of the American Hospital Association. If this action is forthcoming at the A.H.A. convention in September, the joint commission could begin operations soon after the first of the year, it was estimated.

The reluctance of A.M.A. delegates to approve the joint commission proposals as recommended by the board of trustees without qualification was apparent shortly after the house met for the first time. Immediately, several resolutions were introduced raising questions about the proposed accreditation plan, asserting that hospital accreditation should be the function of the A.M.A. alone and seeking specific representation on the commission for special groups within the profession. All the resolutions having to do with

standardization were referred to the reference committee on medical education and hospitals, whose hearings had to be transferred from a conference room to an assembly room at the headquarters hotel to accommodate all the delegates, members and observers who crowded in to take part in and listen to the discussions on hospital accreditation.

As Dr. William Bates of Philadelphia, chairman of the reference committee, explained later to the house of delegates, the committee faced a difficult problem. "During an extended hearing your committee listened to many views, ranging from support of the board of trustees' report [recommending approval of the proposals as presented] to limiting the organizations on the accrediting body to three, two and even one," Dr. Bates told the house. "We think everyone is cognizant of the work of and is grateful to our board of trustees for the emergency handling of a delicate problem in an efficient manner," he added, referring to the hospital standardization contretemps of last September.

Nevertheless, Dr. Bates explained, many members had shown "fear or suspicion of one or another group, both within and without the profession," and the committee had sympathized with those groups seeking to bring standardization "more nearly under control of our own organization."

Actually, two distinct fears had emerged during the committee's hearings: (1) the fear that hospital administrators and trustees, rather than physicians, might set standards and judge performance in connection with the professional aspects of patient care and (2) the fear that professional representation on the commission might be disproportionately high for some groups and inadequate for others unless the A.M.A., as the one body representing the entire profession, controlled the appointments.

CALLS ARRANGEMENT IDEAL

In reply to numerous questions involving these two issues, Dr. Elmer Henderson of Louisville, Ky., A.M.A. president, and Dr. Gunnar Gundersen of LaCrosse, Wis., a member of the board of trustees who took part in the standardization discussions with representatives of the other interested organizations, pointed out repeatedly that 12 of the proposed commission's 18 members would be medical representatives, that A.C.S. and A.C.P. rep-

resentatives would also necessarily be members of the A.M.A., and that the American College of Surgeons, which had conducted the hospital standardization program for many years and was still conducting it, had insisted on joint rather than unilateral medical representation.

In reply to other questions raised during the committee hearings, Drs. Henderson and Gundersen reviewed the history of negotiations and discussions with representatives of the American Hospital Association and American College of Surgeons and reminded critics of the proposals that the A.H.A. had been prepared to go forward with a standardization program of its own, with only limited medical representation. Under the joint plan now proposed, the hospital



group had no intention of "interfering" in professional services, Dr. Henderson explained, but the administrative and professional aspects of hospital standardization had to be considered together.

"This is an ideal arrangement," he concluded, speaking of the joint proposal. "You know me well enough to know that I'm never going to sell the American medical profession down the river. This is no time for us to get into a fight with anybody!"

Dr. Gundersen reported that the A.M.A. board had received an invitation from the American Hospital Association to meet together for discussion of hospital-physician relationships, and that the board had voted to take part in such discussions. Dr. Leland S. McKittrick of Brookline, Mass., urged the committee to approve the trustees' report, pointing out that doctor-hospital conflicts could never be resolved except by cooperative action and the proposed commission offered a specific program for cooperation between the two groups.

After listening politely to one or two members who still wanted to fight and

who described the joint plan as "not compromise but appeasement," the committee retired to consider the evidence and prepare its report.

As it emerged on the floor of the house of delegates the next day, the committee's report took cognizance of the opposition in its suggested "evolutionary process" looking toward eventual strengthening of A.M.A. representation on the commission.

REPORT AMENDED

As it was presented and approved, however, the report did not commit the association or its trustees to any definite program or establish a time limit for the accomplishment of its stated objectives. Instead, the committee asked the house to "further support the board of trustees by recommending that it rearrange slightly the voting power in the commission" to the suggested 8-4-3-3 ratio. "By such an arrangement, an evolutionary process, together with our belief in the astuteness and continued diligence of the board of trustees," the committee concluded, "we believe we can assure those with opposing resolutions and testimony that the best interests of all divisions of the medical profession will be amply protected."

After asking Dr. Henderson and Dr. George F. Lull, association secretary, a few questions about the proposed inspection procedure—again indicating misgivings about lay judgment of professional performance—the house approved an amendment to the report admonishing the trustees in working out further details of the joint accreditation program to "keep in mind the principles elucidated by this house." Then the delegates roundly defeated a motion to refer the report back to the reference committee for further study and, by voice vote, firmly approved the amended report.

While this action plainly put the A.M.A. into the joint accreditation program, the exact meaning of the amendment referring to principles elucidated by the house was in some doubt. The delegate introducing the amendment had referred earlier to the Hess Report, and some thought it was intended to bring the hospital-specialist issues into the accreditation picture. Others regarded it as a less specific recommendation to trustees to proceed warily, bearing in mind the doubts and qualifications that had been expressed in the discussions. Either way,

(Continued on Page 136)

ARE HOSPITALS HOARDING?

Spot survey shows trend toward abnormally high inventories

E. W. JONES

HOSPITAL supply dealers, manufacturers and others have been concerned by the large volume of orders placed by hospitals for medical, surgical, nursing and other professional supplies during the last six months. Are these supplies being used currently or are inventories being increased beyond reasonable operating needs? N.P.A. regulations specifically forbid the use of DO-97 to obtain supplies if inventories are built up beyond reasonable operating requirements.

What are reasonable operating requirements? Where patients' lives are at stake, hospitals must never run out of essential supplies. Depending on such factors as length of time for delivery, fluctuation in outpatient, inpatient and emergency room load, and other factors, most hospitals can operate on a 60 to 120 days' inventory.

In order to get a countrywide picture of hospital inventories on April 1, 1951, as compared with those of June 1, 1950, The MODERN HOSPITAL selected 115 representative general, acute disease hospitals of all sizes and types of control from the 48 states and sent them questionnaires. The great interest of hospital administrators in this problem is shown by 82 usable returns (71.3 per cent). Another 15 hospitals, or just over 13 per cent, wrote letters saying that they did not have inventory figures, but that the inquiry had stimulated them to set up proper inventory controls. Almost 85 per cent of the hospitals receiving the questionnaire, therefore, replied.

Some of the hospitals sending figures were not able to break down their inventory values into the four main categories sought but did furnish overall dollar inventory values or per cent of increase in inventories.

Although the questionnaire asked for separate figures covering (a) med-

Table 1—Comparison of Inventories of Medical, Surgical and Professional Supplies According to Geographical Areas

Geographical Area	Maximum % Inc. Inventory Dollar Value	Minimum % Inc.	Average % Increase	Dollar Inv. Value per Bed June 1, 1950	Dollar Inv. Value per Bed April 1, 1951
New England....	66	0	27	\$ 99.13	\$129.25
Middle Atlantic...	150	11	61	103.67	149.22
Middle West.....	167	23*	41	81.47	119.13
Southeast.....	150	3	37	109.55	148.33
Southwest.....	162	15	94	45.50	96.50
West.....	126	10*	39	141.11	177.80

*Decrease.

Table 2—Comparison of Inventories of Laundry Supplies According to Geographical Areas

Geographical Area	Maximum % Inc. Inventory Dollar Value	Minimum % Inc.	Average % Increase	Dollar Inv. Value per Bed June 1, 1950	Dollar Inv. Value per Bed April 1, 1951
New England....	140	19*	96	\$ 4.20	\$ 9.60
Middle Atlantic...	148	..	70	13.00	22.50
Middle West.....	233	26*	60	9.00	13.91
Southeast.....	130	17*	41	4.56	6.20
Southwest.....	100	..	50	8.00	15.50
West.....	385	18*	53	4.00	6.50

*Decrease.

Table 3—Comparison of Inventories of Housekeeping and Janitorial Supplies According to Geographical Areas

Geographical Area	Maximum % Inc. Inventory Dollar Value	Minimum % Inc.	Average % Increase	Dollar Inv. Value per Bed June 1, 1950	Dollar Inv. Value per Bed April 1, 1951
New England....	80	..	15	\$34.20	\$41.00
Middle Atlantic...	350	9*	98	23.83	43.00
Middle West.....	153	48*	30	21.14	27.71
Southeast.....	103	40*	28	13.36	16.27
Southwest.....	112	50	81	10.50	18.50
West.....	45	35*	50	12.11	18.10

*Decrease.

ical, surgical and professional supplies; (b) laundry supplies; (c) housekeeping and janitorial supplies, and (d) mechanical, maintenance and engineering supplies, the main interest was in figures for the professional items.

The accompanying tables will give the maximum, minimum and average percentage of increase of inventory

dollar value and inventory value per bed by geographical areas for the four inventory groups. (Tables 1, 2, 3 and 4.)

Fourteen of the hospitals were unable to break down inventory figures by separate categories but did give the per cent of total inventory increase between the two study periods. These

Table 4—Comparison of Inventories of Mechanical Maintenance and Engineering Supplies According to Geographical Areas

Geographical Area	Maximum % Inc. Inventory Dollar Value	Minimum % Inc.	Average % Increase	Dollar Inv. Value per Bed June 1, 1950	Dollar Inv. Value per Bed April 1, 1951
New England....	41	64*	5*	\$ 9.67	\$ 9.33
Middle Atlantic....	25	..	11	5.67	6.25
Middle West....	521	..	107	9.54	19.00
Southeast....	229	24*	100	13.00	25.00
Southwest....	160	..	90	5.00	10.00
West....	75	94*	45	5.88	8.33

*Decrease.

Table 5—Total Inventory of Figures of Hospitals That Could Not Break Figures Down Into Four Categories Sought

Hospital	Beds Excl. Basins	Dollar Value June 1, 1950	Dollar Value April 1, 1951	Dollar Increase	% Increase	Inv. per Bed, 1950	Inv. per Bed, 1951
A.....	229	52281	84735	\$32454	62	\$228.30	\$370.02
B.....	188	39931	52370	12439	31	212.40	278.56
C.....	380	20804	40051	19247	92	54.75	105.40
D.....	313	57270	93234	35964	63	182.97	297.87
E.....	107	17281	22900	5619	33	161.50	214.02
F.....	450	76117	95971	19854	26	169.15	213.27
G.....	200	40000	55000	15000	38	200.00	275.00
H.....	300	54212	79855	25643	47	180.71	266.18
I.....	284	93708	126216	32508	35	329.96	444.42
J.....	352	56786	111245	54459	96	161.32	316.04

The other four hospitals in this group gave only the percentage increase in dollar value of inventories.

Table 6—Total Inventories of All Four Categories as Reported by Hospitals Shown in Geographical Area in Tables 1, 2, 3 and 4

Bed Size	Dollar Value per Bed, June 1, 1950			Dollar Value per Bed, April 1, 1951			Av. % Inc. in Inventory per Bed
	Max.	Min.	Av.	Max.	Min.	Av.	
100 beds and under..	143.66	51.00	92.44	225.00	118.52	173.81	88
101-200 beds.....	253.40	49.96	168.51	342.31	91.33	228.80	36
201-400 beds.....	254.97	39.89	134.40	346.00	63.37	170.23	26
Over 400 beds.....	106.89	101.61	104.25	161.27	145.65	153.46	47

showed a maximum increase of 96 per cent, a minimum of 26 per cent and an average of 52 per cent. (Table 5.)

A comparison of inventory figures in bed size groupings also is of interest (Table 6).

The tremendous variation in dollar value of inventory per bed by geographical areas is worth noting. The high of April 1, 1951, for medical, surgical and professional supplies as shown in Table 1 was \$177.80; the low, \$96.50, and the average, \$134.04. From Table 5 (hospitals giving a lump sum for total inventory) the maximum is \$444.42; the minimum, \$105.40, and the average, \$278.08 per bed.

Table 6 (hospitals shown by geographical areas in Tables 1, 2, 3 and 4, but grouped by bed size) shows a maximum of \$346.00; a minimum of \$63.37, and an average of \$180.00

per bed for the total inventory. This is an increase of 49 per cent.

In considering the percentage increase in inventory dollar value between the two periods, one must remember that this is partly the result of unit price increases. Two of the largest hospital equipment and supply dealers report an average price increase between June 1, 1950, and April 1, 1951, of approximately 15 per cent. However, after applying this corrective factor, it is apparent that hospitals have considerably increased the actual physical volume of their inventories.

If one considers the needs of civilian defense programs and the necessity of hospitals making some inventory increase as a result of requests from civilian defense authorities, it still seems that some hospitals have increased inventories beyond reasonable and foreseeable needs. If this

trend continues, artificial shortages are bound to occur. The tying up of sums as large as are shown by some hospital inventories is questionable from the standpoint of sound administration. The artificial demand built up by these great increases in inventory can mislead manufacturers, dealers and federal government officials in their claimant agency estimates and programs.

The time has come to give careful study to:

1. Establishment of perpetual inventories and controls on all stock groups according to the A.H.A. standard chart of accounts.

2. Study of purchases and inventory volume of such items as gauze, surgical dressings, hypodermic needles and sutures with representatives of dealers and manufacturers to see how purchases and deliveries can be evenly spaced throughout the year. In many specific cases, valuable working capital has been released by such studies. Economies through use of proper sizes and types also can be made.¹ Procedural studies in handling and preparing such items as hypodermic needles will save money.²

3. Inauguration of a simplification and standards program for procedures and supplies; study of the Simplified Practice and Commercial Standards reports in the 28th (1951) edition of the *Hospital Purchasing File*.

4. Anticipation of needs by long-range planning and cooperation with dealers and manufacturers in a purchasing and stores program.

5. When hospitals receive (in July) the consumption questionnaire coming from the U. S. Public Health Service, they should fill it out accurately and promptly. George Bugbee's letter of April 6, 1951, to all A.H.A. members fully explained the importance of this matter. The *MODERN HOSPITAL* for June in an editorial entitled "Answer the Man's Questions" pointed out the great importance of this undertaking.

Hospital administrators must remember that their claimant agency in Washington, the Division of Civilian Health Requirements, U.S.P.H.S., cannot adequately present their case to the Defense Production Administration and the National Production Authority without accurate figures.

¹Brown, John L.: How to Save Surgical Gauze, *Mod. Hosp.* 76:81 (May) 1948.

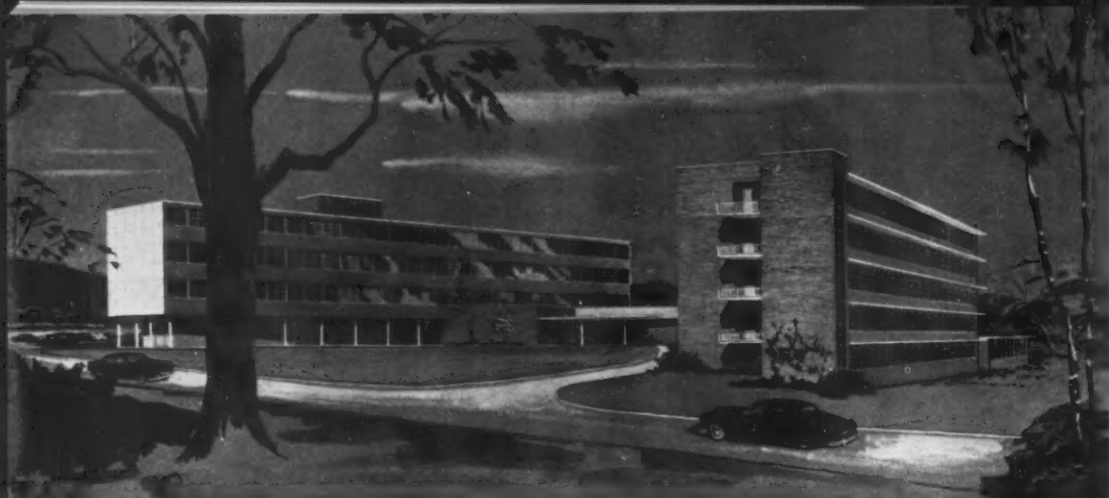
²Bindel, Catherine A.: Central Supply Is Root of Good Service, *Mod. Hosp.* 71:70 (December) 1948.



BRISTOL BUILDS A LIVING MEMORIAL

A. L. AYDELOTT & ASSOCIATES
Architects and Engineers, Memphis, Tenn.





BRISTOL MEMORIAL HOSPITAL, BRISTOL, TENN.-VA.

THE MODERN HOSPITAL OF THE MONTH

IMEDIATELY following World War II the question of war memorials was a consideration in every U.S. community of size. From the days of the Civil War monument gracing the courthouse square we had advanced to the point of considering more realistic means of honoring our war dead.

Veterans who returned to Bristol, Tennessee-Virginia, suggested to representative business and professional men of the town that no better memorial could be offered than a modern hospital facility to augment or replace the inadequate Kings Mountain Hospital which had been in operation for more than 25 years.

A plan for adding space to the existing hospital was projected and cost estimates were developed. In consideration of the bad condition of the existing building and its lack of suitability for alterations it was decided to attempt the more ambitious project of a new and complete health facility. The only means possible for such an undertaking lay in getting assistance under the federal hospital grant-in-aid program.

Bristol, situated as it is on the Virginia-Tennessee state line, became an "orphan" under this federal program, in spite of the fact that with a population of 34,500 it is the largest city of the two counties in which it is located. Its population is divided about equally between the two states

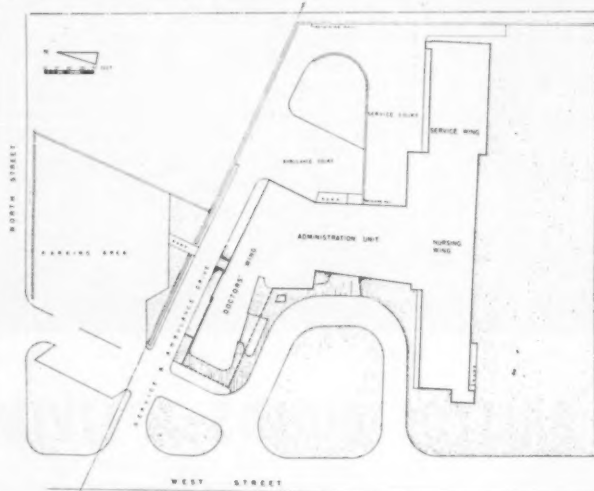
and in the state plans a true picture of its importance in connection with either state could never be reflected. Consequently, Bristol was unable to obtain assistance from either Virginia or Tennessee under the published state plans.

After the hospital had been "dis-owned" by both states an application was eventually accepted and approved by the Tennessee State Hospital Agency. The extent of approval, how-

ever, was for 80 beds, which would not meet the need.

After receiving limited approval the Bristol group organized a fund-raising campaign, setting a goal of sufficient money to add 40 beds to the approved allotment.

Also projected in the planning was a building large enough to furnish office space for most of the Bristol doctors. The development of space requirements in this case was likewise



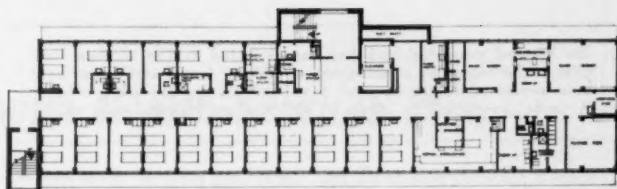
Plot plan of hospital. Diagonal cutting plan is Virginia-Tennessee state line.

made difficult by budget requirements established by the state agency. The cost of providing adequate space for doctors created an apparently unbalanced cost per hospital bed. Therefore enough additional funds had to be raised to augment the amount budgeted under grant-in-aid.

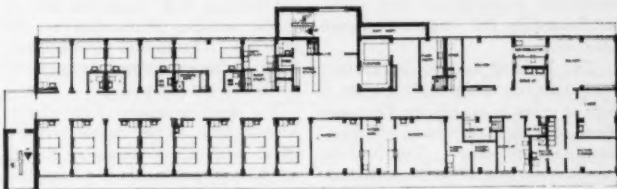
The basic plans were then developed with a capacity of 80 patients' beds and space for 14 doctors. Alternates were developed providing an additional floor in both the hospital and doctors' building. The additional hospital floor brought the total capacity to 120 beds, and provided space for a total of 22 doctors.

A nurses' home and training school has been projected for future construction. This unit will complete the group of three buildings essential to a complete facility, and will permit a high level of health care for the entire area. After much consideration by the hospital board and discussions among doctors and local druggists, it was decided to incorporate a commercial pharmacy and soda bar in the doctors' building section. This facility will serve doctors' patients, outpatients, and the hospital. While no solution manufacturing is contemplated, registered pharmacists will be on 16 hour a day duty for compounding prescriptions and dispensing drugs to the floors.

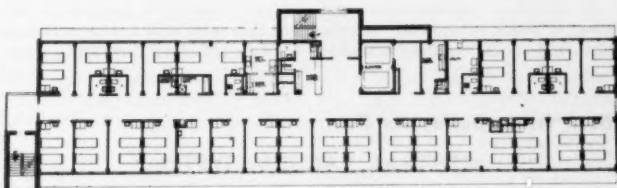
The disposition of elements in the building was determined primarily by consideration of the site. Bristol is mountainous, and land with gentle



The top floor accommodates the surgical suites and central sterilization.



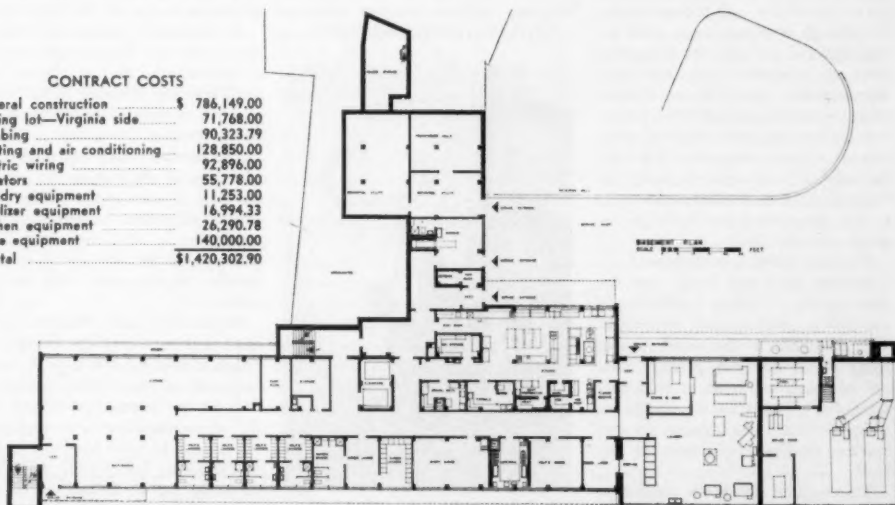
Delivery rooms, nurseries and maternity beds comprise the third floor.



The second floor is a typical nursing floor, largely semiprivate in nature.

CONTRACT COSTS

General construction	\$ 786,149.00
Parking lot—Virginia side	71,768.00
Plumbing	90,323.79
Heating and air conditioning	128,850.00
Electric wiring	92,896.00
Elevators	55,778.00
Laundry equipment	11,253.00
Sterilizer equipment	16,994.33
Kitchen equipment	26,290.78
Loose equipment	140,000.00
Total	\$1,420,302.90



Kitchens and staff dining rooms, locker rooms for employees, laundry and boiler room occupy basement space.

The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital, the architects and the state officials. A similar award will be made by The Modern Hospital each month.

contours is practically nonexistent. The site selected for the hospital was determined by possibilities of orientation and view to beautiful mountainous scenery. This property is ideally located with respect to the town, and is subdivided by the Virginia-Tennessee state line.

The building had to be planned within the boundaries of the Tennessee side in order to qualify for Tennessee funds and this conditioned the planning to some extent. The patients' pavilion was placed on the south side and the patients' rooms are exposed to southern sun and breezes together with a spectacular view of the mountains.

A one-story administration unit serves as a link between the patients' block and doctors' building located at

the extreme north end of the property. The angular relationship of the doctors' building to the patients' block was dictated by the direction of the state line which it parallels. The building through such angulation has its closest possible relationship to the state line. This in turn permits maximum distance between the patients' block and the street.

The planning feature of the administration unit is the double corridor which permits circulation by doctors and hospital personnel away from visitor traffic. Adjacent facilities and emergency department are placed alongside the service corridor side of the administration wing. The ambulance entrance is arranged on the first floor level, with a ramp extending from the ambulance drive into a lower

local service court. This service court opens on to the morgue, kitchen and a service entrance, which is controlled by the housekeeper.

Public entrance to the building is by means of a drive which opens directly under the main entrance canopy and a separate covered entrance to the outpatients' section as well. Parking area for both doctors' building and hospital is provided on the Virginia side of the property. The nurses' home and school, which is tentatively approved under the Virginia state plan, is to be located in an area adjoining the parking area. Garden walls will screen noise and traffic and provide privacy in the nursing school area.

Patients' rooms are provided on the first floor. Here a small segregated section incorporating 14 beds is set aside for colored patients in accord with local requirements.

The second floor of the hospital is the alternate floor which provides 39 beds above the court incorporated in the basic scheme. Third floor incorporates delivery suite and accommodates 19 obstetrical patients.

Fourth floor combines surgical and cystoscopic facilities which adjoin the central sterilization room. A dumbwaiter from central sterilization to delivery and other floors makes possible a convenient and expedient service of supplies.

All rooms are private or semiprivate. In peak loads private rooms may be doubled, which furnishes room for a maximum census of 142 beds.

A penthouse apartment with an open south wall offers a real incentive to interns, who may be drawn from the University Hospital in Richmond to serve a year of residency at the Bristol hospital.

The basement floor which takes full advantage of the sloping site is above grade in all areas except storage. This affords maximum natural light and ventilation in all service areas. The laundry and kitchen are planned to handle the completed bed complement.

Bristol Memorial Hospital is as much a memorial to the tenacity and imagination of the Bristol group, which originally set the idea in motion, as it is to the veterans of World War II. Certainly, here is a monument which may be used to the advantage of the living for a great number of years, and is, we believe, a welcome transition from the bronze marker in the town square.

Beth Israel Builds Its Own

CENTRAL VACUUM SYSTEM

WHEN the new addition to Beth Israel Hospital, Boston, was completed the problem arose as to the best method of utilizing the central vacuum system installed in each patient's room. A thorough investigation of available apparatus did not give the hospital a piece of equipment that was light, maneuverable, acceptable in appearance, and with a positive vacuum control. By combining the standard products of various companies, and with the help of some small work by the hospital maintenance department, the suction apparatus shown in the photograph was developed.

This equipment is made basically of a stainless metal kick bucket with inserts capable of holding a gallon bottle (as shown) with a small trap bottle. This adaptation, with a small vacuum gauge which does not permit "build up" of vacuum proved to be highly successful. The vacuum system is easily controlled and requires no wall brackets or fixed equipment of any kind.

This vacuum trap bottle equipment has been used with good results in all parts of the hospital including nur-

series and general wards. The reaction of nurses and doctors using it has been good, and several hospitals have expressed interest in the same setup.—NELSON LINDLEY, assistant administrator, Beth Israel Hospital, Boston.



Stainless metal kick bucket holds a gallon bottle and trap bottle.

Saskatchewan Health Services Plan

a compulsory hospital care insurance program

that has hospital association approval

THE issue of health insurance has changed from one of argument about aims to one of disagreement on methods; the question is no longer whether health insurance is desirable, but rather how the advantages of prepaid health care can best be made available to all, within the framework of existing institutions.

In the long run, many issues and problems which now appear to be subordinate will likely prove to be of considerably more significance than the one about which there is now the greatest amount of controversy, the respective rôles of government, hospitals, health professions, and existing agencies in the financing, organization and administration of a comprehensive health insurance program.

The democratic process through which social and political policies are made requires intelligent decisions by an informed electorate. Hence, the spotlight of objectivity must at all times be used to define clearly the true facts of any issue.

APPLICABLE TO AMERICAN SCENE

What makes this question of responsibility for health insurance administration particularly difficult to resolve is that most of the experience, from which objective conclusions might be drawn, is European, and hence frequently rejected on the ground that it is not applicable in the American scene. Accordingly, it may be of value to observe a government-administered program which, while covering the residents of a Canadian province rather than those of an American state, nevertheless operates in an economic and social context similar to that in many of the states.

This article is based on a chapter of the writer's dissertation submitted in satisfaction of the requirement for the degree of doctor of philosophy to the department of political science, University of California, 1949.

MALCOLM G. TAYLOR

Regina, Sask.

The postwar period in Canada has been characterized by unprecedented activity and interest in health insurance. In 1943 and 1944, a committee of the Canadian House of Commons made an exhaustive study of health insurance and prepared recommendations for a national program for Canada. In 1945, the federal government acted on these recommendations by proposing federal grants toward health insurance programs to be established and administered by the provinces.

The failure to achieve an agreement by all of the provinces to the financial terms involved has so far precluded adoption of these proposals, but the federal government has made wise use of the delay by laying a more solid foundation for the eventual adoption of health insurance through its program of health grants for hospital construction, for strengthening of public health services, and for professional education.

In the meantime, without waiting for federal grant assistance, two provinces have adopted government hospital care programs providing universal coverage and financed by compulsory tax levies. The first of these plans was inaugurated by Saskatchewan in 1947 and the second—modeled along similar lines—by British Columbia in 1949.

There are many ways in which the evaluation of a social program might be attempted. The problem in making an evaluation is the difficulty of obtaining criteria acceptable to many points of view. Fortunately, in Canada, such objective criteria are available. They are minimum essentials established by those most affected, the hospitals themselves.

Between 1939 and 1942, when federal health officials were consulting

with committees of the various professional associations in the framing of health insurance legislation, the Canadian Hospital Council agreed upon a series of principles or conditions which should obtain under any form of health insurance providing hospital care benefits. These principles were set forth in a brief presented to the House of Commons' Committee on Social Security in 1943.*

EVALUATION OF PLAN

It is proposed, therefore, to evaluate the Saskatchewan Hospital Services Plan (SHSP) in terms of these requirements considered to be essential by the provincial and Catholic hospital associations, members of the Canadian Hospital Council. Not all of these principles are completely relevant in the United States, but they provide excellent "yardsticks" for objective measurement of a governmental program in action.

1. Voluntary hospitals should be utilized. In Canada, there is no distinction between voluntary nonprofit hospitals and municipal hospitals with respect to admitting different categories of patients. Both types admit self-pay patients and indigent patients. No system of separate hospitals for indigents has developed. In Saskatchewan, voluntary and municipally owned hospitals are approved in accordance with the same standards, and, when approved, are eligible for payment from SHSP. Although a grants-in-aid program for hospital construction was inaugurated in 1945 by the provincial government (and by the federal government in 1948), the construction, ownership and operation of hospitals is a local responsibility.

2. Hospitalization should be through "public" hospitals. The

*Canadian Hospital Council, Principles of Health Insurance as They Relate to Hospitals, (Toronto: The Council, 1942).

Canadian Hospital Council stated as a principle that, except in certain rural areas which might be served only by proprietary hospitals, hospitals eligible to receive payment for service to insured patients should be those recognized by the provincial governments as "public" hospitals, that is, either nonprofit voluntary hospitals (lay or religious) or municipally owned hospitals. This principle has been followed precisely as laid down by the council. The only proprietary hospitals approved for payment have been privately owned nursing homes in areas where there are no longer hospitals.

3. Hospitalization benefits should be reasonably complete. The hospital benefits of SHSP cover virtually all the essential inpatient services provided by a hospital and since hospitals are paid an "all-inclusive" rate which covers their cost of operation, it is fair to say that this requirement has been adequately met. What is equally important is that there are no exclusions for preexisting conditions, no restrictions because of age, no limitation on length of stay that is medically required, no "dollar limits" on benefits of any kind. All of these must be considered in measuring the extent to which SHSP meets the community's true hospital care needs.

4. Facilities should be made available for all types of patients. General hospital facilities in the province now provide seven beds per thousand population, adequate to take care of acute, convalescent and "active chronic" patients.² Each year, the total number of beds has been increased and their distribution improved. There is some evidence that certain convalescent and long-term cases could be adequately cared for in other facilities, but the supply of beds in such institutions, though improving, is not yet adequate.

The province has an adequate number of tuberculosis beds and the mental hospitals, while overcrowded, have no waiting lists. Treatment in both of these types of institutions is provided without cost to the patient.

5. Hospitalization of "indigents," or those unable to pay, should be provided for under the plan. Complete conformance with this principle is one of the outstanding characteristics of SHSP. All persons receiving old age pensions, blind pensions, mothers' allowances, and provincial social aid receive a hospital services card for which

the provincial government pays not only the "premium rate" but the actual cost of the hospital care received which is, of course, in excess of the average. Municipal governments are required to pay the hospitalization tax on behalf of all persons for whose hospital care they are responsible. This means that the hospitals receive patient day payments on behalf of indigent patients at precisely the same rates as for all other patients, the rates being geared to meet the actual costs of operation.

6. Dependents of the insured should be included. Under the act, every taxpayer is liable for payment of the tax (or premium) levied on himself and his dependents. The tax is graduated according to size of family, from \$10 per year for a single person to a maximum of \$30 for a family of four or more. There is no distinction between the benefits available to the taxpayer and those to his dependents.

7. Remuneration of hospitals should be adequate. During the first year of operation of the plan, hospitals were remunerated according to the "units of credit" system formulated by Dr. Harvey Agnew, executive director of the Canadian Hospital Council.³ Because this method of payment resulted in deficits for a number of hospitals (and surpluses for others), the "point" system was abandoned in favor of a payment policy based on the costs of operation of each hospital. The result of this payment method has been to make hospital deficits virtually a thing of the past in Saskatchewan. This has been a boon not only to hospitals but also to the municipal and other authorities formerly required to make up the deficits.

8. Basis of remuneration should be fair to all parties concerned. The basis of remuneration of hospitals has been, at every step, worked out in full collaboration with representatives of the provincial hospital association and of the Catholic Hospital Conference. As hospitals improve their facilities and add personnel to their staffs (including the schools of nursing operated in conjunction with the hospitals), or as other costs rise, the rates of remuneration are increased. Any hospital is free at any time to ask for a review of its rate.

9. Hospitals should maintain the right to determine their staffing privileges. This right, so essential in the

provision of a high quality of care, has not been interfered with in any respect by SHSP.

10. Insured persons should have the privilege of taking higher priced accommodations by paying the difference in charges. This principle has been accepted from the beginning. A patient may choose any type of accommodation he wishes. In the event that all minimal accommodation beds are filled, a patient (unless it is an elective case) is entitled to semiprivate or private accommodation without extra charge.

11. Health insurance should be on a provincial basis under federal coordination. The plan has been set up, of course, on a provincial basis and, until the federal proposals of 1945 for national health insurance come into effect, the principle of federal coordination cannot apply.

12. Direction of the plan should be strictly nonpolitical. It would probably be impossible to obtain complete agreement on the criteria to be used for evaluating the operation of this principle in practice. But it appears fair to state that the hospital services plan is administered about as nonpolitically as it is possible for a man-made institution to function. The evidence follows:

All appointments to the administration are made by the Public Service Commission and involve open competition, panel selection, and promotion within the service on a merit basis.

The hospital services plan has been endorsed by the hospital association.

The hospital services plan has been endorsed by the Saskatchewan College of Physicians and Surgeons.

The hospital services plan has been endorsed by both the urban and rural municipal associations.

At the last provincial election (in 1948), neither of the two opposing political parties criticized the hospital services plan except to contend that each could provide the same service at less cost.

The ratio of administrative cost to total expenditure is now 5 per cent, the total cost of administration having been reduced each year.

13. There should be hospital representation on the commission or advisory council. The hospital association and the Catholic Hospital Conference are represented on the advisory committee of the Health Services Planning Commission. The commission also meets periodically with the

²The bed-death ratio is 1.19 and the bed-birth ratio is 0.025.

³The system was described in *Hospitals*, January, 1944, pp. 21-24.

executives of the hospital association and the Catholic Hospital Conference to discuss mutual problems and, in addition, arranges meetings with special committees on such matters as drugs, addition of benefits, training of personnel, review of rate-setting policies and decisions.

14. The health insurance fund should be a contributory one. Contributory insurance is the basic principle underlying the financing of the hospital services plan. The provincial government makes a substantial contribution, however, to cover the costs of programs for which it was previously responsible, including the cost of hospitalizing indigents, as has been mentioned, the cost of hospitalizing all cancer patients, and a contribution in lieu of the per diem grants which had been previously made to hospitals. Inasmuch as this is not sufficient to

meet the costs of the hospital services plan, the provincial government makes an additional contribution from provincial general revenues as an alternative to raising the beneficiary's tax or premium payment beyond the capacity of a majority of the residents of the province to pay. Only by a provincial subsidy of this type can such full-range benefits be brought within the financial capacity of lower income groups.

The Saskatchewan Hospital Services Plan is, therefore, a successful demonstration that a government administered hospital care insurance program can readily meet the exacting standards established by the hospitals themselves through their associations and can achieve at the same time that desirable objective, universal coverage. Hospital care is within the reach of every Saskatchewan resident and thousands of people who would not otherwise have

been able to afford it are receiving the hospital care they need.

At the same time the quality of care is being improved. Not only is the remuneration of hospitals adequate to provide an increasingly higher level of service, but hospital administrators are freed from the necessity of being "fund raisers," and can now devote their entire energies and talents to the primary task of administering their hospitals.

Security is desirable but there must also be freedom. The most notable achievement of the Saskatchewan Hospital Services Plan is the proof it has given, in four years of experience, that freedom and security are not mutually exclusive but that, in fact, with greater security there is more freedom. It is possible to devise a program for complete hospital care for everyone which also assures more freedom for patients, hospitals and professional staff alike.

Permanente has the answer to **LIVING-IN PROBLEMS**

THE diagram shows the planned obstetrical floors of the new Permanente Hospitals. We think the new nursery layout will be the answer to all discussions attached to living-in problems. Each bed has a nursery situated behind it which permits the baby to be either in with the mother or back in the nursery. The bassinet will pull through very much as a file drawer pulls out of a filing cabinet. When the bassinet is returned to the nursery, a light automatically notifies the nurse on duty that the baby is back in the

nursery. A viewing window above the bassinet permits relatives to see the baby while visiting the mother; yet the baby is back in the nursery behind soundproof walls.

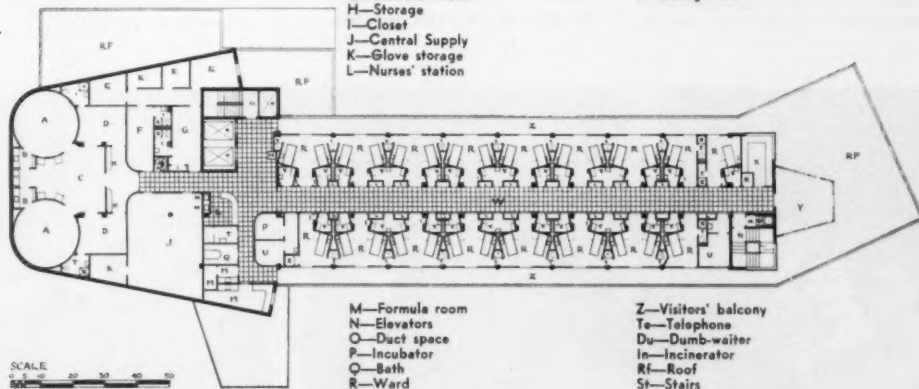
The outside corridors marked "Z" are for use of the public which will be kept out of the central corridor; this

will be reserved solely for the use of hospital staff. The central corridor will be controlled from the control station marked "L" next to the elevators. Both walls of the outside corridors are of floor to ceiling glass and the building is completely air conditioned.—SIDNEY R. GARFIELD, M.D.

ROOM SCHEDULE

A—Delivery
B—Clean-up
C—Work space
D—Labor room
E—Sleeping room
F—Nurses' room
G—Doctors' room
H—Storage
I—Closet
J—Central Supply
K—Glove storage
L—Nurses' station

S—Shower
T—Toilet
U—Isolation Nursery
V—Regular nursery
W—Work corridor
X—Kitchen
Y—Dining room



M—Formula room
N—Elevators
O—Duct space
P—Incubator
Q—Bath
R—Ward

Z—Visitors' balcony
Te—Telephone
Du—Dumb-waiter
In—Incinerator
Rf—Roof
St—Stairs

CONFERENCE TECHNIC

takes a great deal of time and costs considerable in terms of time off job, but it's worth everything you can put into it

THERE are many ways in which the problem of public relations can be tackled and all of them have been considered at New Britain General Hospital in New Britain, Conn. Publicity, use of human interest stories in the press, repairing and redecorating the plant, and training programs, all constitute ways and means of correcting poor public relations. We are doing all of them, but this article will be confined to the employee training program we are conducting at the present time.

We started off with the premise that "good public relations starts with in your own hospital and its employees." We felt that every employee who comes in contact with the public should take the course. The next step was to decide the method of teaching. I had had experience with the conference method during my industrial experience and suggested to the personnel policy committee that it be used. This committee is made up of the managing director, the assistant to the director, the director of nurses, the chief pathologist, and the director of patient and employee relations.

The conference method is one that is used extensively by the Vocational Training Division of the Connecticut Department of Education in training

JAMES L. BISHOP
Director of Patient and
Employee Relations
New Britain General Hospital
New Britain, Conn.

courses for executives, supervisors and public relations officers in Connecticut industry. S. Y. Spaulding, training supervisor, was called in to explain to the personnel policy committee just what the conference procedure was and how it could be used to help solve our problem.

After it was decided to use the conference method, Mr. Spaulding with my aid developed a course made up of 10 two-hour conferences dealing with the subjects listed in the accompanying outline. Two methods are used by the Connecticut Department of Education in conducting its work. One way is to send one of its own trained conference leaders to handle the sessions; the other is to train as many of the hospital's own people to be conference leaders as are necessary. The latter method was chosen because there were 425 employees to

be given the series of 10 conferences and it seemed more expedient to have as many leaders available as possible. These leaders were to be given a concentrated 40 hour training course in the technic of conference leadership under the direction of Mr. Spaulding.

The next problem was to pick out suitable candidates for the leadership course. This job was delegated to the personnel policy committee. The committee had been given the necessary qualifications of a good conference leader, which include such qualities as: pleasant personality, poise, ability to think on his feet, good judgment, tact and the ability to express his own thoughts and those of other people clearly and concisely.

It was decided to pick individuals from as many departments as possible in order that we would have a representative group of leaders. The people who were finally chosen held the following positions in the hospital: (1) chief medical record librarian, (2) director of student nurse health and recreation, (3) admitting officer, (4) receptionist, (5) assistant dietitian, (6) administrative trainee, (7) ward secretary, (8) bookkeeper, (9) secretary of the blood bank, (10) head nurse of pediatrics, and (11). the

(Continued on Page 64)

One of the training sessions of conference leaders in New Britain General Hospital's program.



CONFERENCE SCHEDULE WORKED OUT BY NEW BRITAIN GENERAL HOSPITAL

CONFERENCE 1:

Organization—supervisory position
Workers and what makes production tick
The part that "cooperation" plays

CONFERENCE 2:

WHAT IS PUBLIC RELATIONS?
Trends in public relations
Factors affecting public relations
A—Advantages
B—Disadvantages
WHAT IS PUBLIC OPINION?
A—Advantages

CONFERENCE 3:

ATTITUDES
A—Evidence of undesirable attitudes
B—Evidence of desirable attitudes
C—How to influence attitudes
The anatomy of "attitude"
WINNING CONFIDENCE
A—Factors affecting confidence
B—Methods of using these factors
Interests and how they work

CONFERENCE 4:

WHO OR WHAT IS THE
NEW BRITAIN GENERAL HOSPITAL?
What is included in the makeup of the hospital?
What groups of people form the personnel?
What does the hospital provide the customer?
What is necessary to provide hospital service?
What is the value of the New Britain General Hospital?
Develop a brief "laundry list" from above questions
Employees—What are the qualities of a good employee?
Equipment—What equipment is necessary for the hospital to conduct its business?
Money—Where does the hospital get money?
What are the various sources of income?
Customers—Who are the customers of the hospital?
How much of our revenue is from customers?
FUNDAMENTAL PURPOSE OF ANY BUSINESS
Wants—
Employees
Customers
Owners
Public
How can they be satisfied?
Contributions to the economic life of New Britain
COMPETITORS OF YOUR COMMUNITY
Who are our competitors?
Advantages to public
How does competition help?
What can be done to meet competition?
Importance of good will and its application to your business

CONFERENCE 5:

BUILDING MORALE
Blackboard—What is morale?
(Get definition of morale from group)

For leader's use only—"Morale is the state of mind of individuals and groups growing out of the conditions under which they work, including their working conditions, their work, their associations, and the supervision they receive."

Blackboard—What is the effect of low morale?
*Supervisors Employees Management
Customers*

Blackboard—How to build up morale?

CONFERENCE 6:

IMPORTANCE OF HUMAN ELEMENT
Develop a list for each of the following headings:
Discourteous employee
Indifferent employee
Dissatisfied employee
Incompetent employee
Uncomfortable customers
Dissatisfied customers

Blackboard—Causes of dissatisfaction
Blackboard—Ways of correction
Blackboard—What is good will?

Develop a list of each of the following headings:
Why is customer good will important?
Why is employee good will important?
Why is public good will important?

CONFERENCE 7:

THE EMPLOYEE ON THE JOB
Develop two lists
Direct Contacts Indirect Contacts
IMPORTANCE OF PERSONAL APPEARANCE
Develop a list of those things which help in creating a favorable impression
Develop each heading separately
Clothing—Personal—Characteristics and Mannerisms
Unfavorable—Favorable

CONFERENCE 8:

THE EMPLOYEE OFF THE JOB
Does the employee always represent the hospital?
Is the employee part of the public?
How does the employee help to form public opinion?
Are many people antagonistic to the hospital?
How does the employee's attitude influence public opinion?
How does personal appearance affect public opinion?
Why is character important?
What opportunities does the employee have to foster good public relations while off the job?
Blackboard—Opportunities (List)

CONFERENCE 9:

Discuss the following:
A. Publicity *versus* public relations
B. Propaganda or education
C. Criteria for evaluating public relations
D. Technics of public relations
E. Complaints and how to handle them
F. Patterns for good public relations
G. Supervision and training

CONFERENCE 10:

General Discussion on These Statements

1. The New Britain General Hospital is never justified in rendering any service to customers which does not in itself produce a profit.
2. Hospitals can successfully compete with any form of fair competition.
3. Citizens are taxed to help some competitors of the New Britain General Hospital.
4. Higher rates always bring greater profits.
5. Good equipment is an essential part of good service.
6. Personal appearance of equipment is important in public relations.
7. Personal appearance of employees is important in public relations.
8. Excuses do not build public good will.
9. Broken promises tend to destroy good will.
10. Public opinion is subject to change and can be influenced by education.
11. If public opinion is wrong, it is wrong because of wrong information.
12. It is the obligation of all individuals who come before the public to see that the public has full and correct information.
13. An employee may correct misstatements or wrong information on the part of the customer.
14. An employee should never argue with a customer.
15. An employee should never lose his temper or show any discourtesy to the customer.
16. In any discussion or disagreement it is always wise to get the other fellow to talk freely while you listen attentively. Try to find something with which you agree.
17. Good will is a financial asset to the New Britain General Hospital.
18. Good employee-employer relations make the employee's job and the investor's dollar more secure.
19. The future prosperity of this country is largely dependent upon the service hospitals.
20. The New Britain General Hospital has more advantages to offer the individual looking for a job than have other business organizations.
21. Hospitals are operated for service to and convenience of the public.
22. Hospitals are given special privileges.
23. Conflicts are mostly due to misunderstanding and distrust.
24. Employees and employers have many more mutual interests than conflicting wants.
25. Preferential service may destroy good will.
26. Loyalty is an equal obligation of the employee and the employer.
27. There is always room for improvement of service and the individual.
28. A good employee of the New Britain General Hospital must be well informed.
29. The employee's influence on public relations begins at home.

director of patient and employee relations.

This group was called together and given an outline of the entire program. Each person was asked if he wanted to participate and to be a leader. All accepted and they started their training. We met for eight hours a day for five days.

During the 40 hours, we learned the technics of using overhead questions (how, when, where, what, why); the art of summarizing; how to start cross discussion; how to draw out the quiet conferee and quiet down the consistent talker; how to hold back our own opinions and bring out those of the conferees; how to be merely a secretary for the group and not a teacher. Besides learning these technics, we each led a short conference on two or more of the subjects which we were eventually to have with our various groups.

WIRE RECORDER USED

After each embryonic leader had got through his trial, he was subjected to severe and constructive criticism by the rest of the group and our instructor. Each one was enthusiastic about the whole program and took the criticism in good spirit. Another device used was a wire recorder. This was a great help as it enabled us to recognize our faults and made us realize what our voices and vocal mannerisms sounded like to other people.

We were also given instruction on how to measure the flow of discussion, list the areas of responsibility, which of these areas was the most difficult and reasons why; how to plan a conference, how to conduct one, and how to measure its effectiveness as a conference. Several members of the personnel policy committee sat in on our sessions. They became very enthusiastic and interested. In fact, one can almost see the effects of their exposure to conference methods as they conduct meetings of their own at the present time.

At the end of the forty hours, our instructor felt that nine of the 11 leaders were all set to go; the other two would be ready after a little more practice. The next problem was to keep up the enthusiasm of the group until we could get the main program started. However, this was taken care of by the members themselves. They decided to meet once a week for practice after their regular hours and on their own time.

In the meantime, four groups of 15 employees were organized and a leader was assigned to each group. One of the groups was made up of department heads; the others, of employees from various departments. We tried not to have more than three from any one department in a single group and not to put people under the leadership of anyone who would have direct supervision of them. These groups meet once a week for two hours and discuss the scheduled topic. The conferees do not know the topic until they gather around the table at the appointed time. These conferences are held on hospital time from 1:30 to 3:30 p.m. They are held in the library of the nursing school with the conferees sitting around a long table. Our equipment consists of two two-sided blackboards, erasers and plenty of chalk.

After each conference, the leader summarizes the thoughts of the group; copies of the summary are made and distributed at the next session. Each individual is given a binder in which to keep his summaries. At the end of the series, a certificate will be given to each conferee. The conference leaders also were given a certificate for the leadership training. These certificates are given by the state and printed with the seal or insignia of the hospital.

A questionnaire was given to each of the conferees at the conclusion of the series. Questions asked were designed to elicit their opinion concerning the course. Ninety-two people have taken it so far and some of the results of the questionnaire are as follows:

59—felt the discussions were of definite benefit

26—felt the discussions were useful
5—were doubtful as to their value
2—no reply

58—were interested in having them continued

20—were not interested in having them continued
14—no reply

61—wanted similar meetings resumed at a later date

16—did not want similar meetings resumed at a later date
15—no reply

62—had a better understanding of the hospital

50—had a better understanding of their own responsibilities

36—got and gave better cooperation

22—were helped in understanding shortcomings of superiors

69—were helped in understanding their own shortcomings

77—felt that management was definitely interested in getting ideas of group and applying them

1—did not feel there was any interest

These comments gave us a good idea of our employees' reactions. However, the final results will be determined by the attitude of our patients and public toward the hospital and its employees. Our employees are beginning to be interested in the hospital and its problems. They are beginning to see just what their place is in the whole picture. They are beginning to realize that they are selling personal service to people who are sick and uncomfortable. That may sound foolish, but many of our people up to now seemed to have overlooked that fact.

WORTH THE TIME AND MONEY

We in the administration are finding out what our employees think about us. We find that each group unknowingly will list the same things under the various headings. When so many say the same thing, we should take heed. We will follow through on as many as we can when we can, but we will not let their suggestions go unheeded or unanswered.

These conferences are just the beginning; other programs will follow. It takes a great deal of time and is costing a large sum in terms of time off the job, but if we can continue to hear people say "My, but this place has improved," we will say it is worth everything we have put into it.

PATIENCE!

MANY students of public health and hospital administration have asked me to tell them what I consider the major qualities of the hospital executive and I have always placed the virtue of patience prominently among them—patience with people and patience with circumstances. One must know how to lose a battle in order to win a war, how to fight a rearguard action while waiting for the tide to turn and reinforcements to come into play, and how to keep the goal in view when it is obscured by passing clouds.

No temperamental executive has ever been a success, nor has an executive whose temper is not under control at all times. The people who surround him may be excited and rebellious, and the circumstances may be equally provocative, but he must maintain his equilibrium at all times, showing an example and continuing to inspire confidence in others for the judgments by which he and his hospital survive.—E. M. BLUESTONE, M.D.



THE need for trained hospital administrators has long been apparent in the United States. Of late years the need has become acute. This is due to several reasons.

Advances in medical science and the consequent greater use of hospitals make it more important that those hospitals be operated efficiently. Growth of prepayment hospital plans, as well as universal health consciousness, makes further demands upon our hospitals.

More and better hospitals are needed. And they are being built—both with federal financial aid under the Hill-Burton program and solely with private capital. Many hospitals have been completed and more are under construction. All will need administrators.

To meet the demand for trained personnel, the schools of hospital administration are graduating about 125 potential administrators per year. This number will just about provide for the normal turnover. Further, these university trained people are attracted mainly to positions in the larger institutions. Smaller hospitals must secure

their people from other sources. Thus it is plain that additional steps must be taken to provide competent administration for many of the new hospitals.

Being extremely conscious of this tremendous and growing need, the Division of Medical and Hospital Resources has conducted a number of symposiums or institutes designed to give potential administrators a brief but intensive course of instruction. These sessions were designed not to give answers to all questions, but to point out the problems that would arise and where answers might be found. The courses were enthusiastically received.

A number of organizations, state officials and individuals have asked that this material be made available to help them conduct similar courses in their areas. The work of compiling the material has been done by Edward L. Tolson Jr., Hospital Consultant, Division of Medical and Hospital Resources, Public Health Service, Federal Security Agency. —J. R. MCGIBONY, *Medical Director, Chief, Division of Medical and Hospital Resources.*

INTRODUCTION

Who initiates action to organize an institute?

An institute may be sponsored by an official state agency, a private organization or a university. The "state agency" normally would be the bureau responsible for administering the Hospital Survey and Construction Act, the hospital licensure program or both. Private organizations which might sponsor an institute include the state hospital association, area hospital councils or a philanthropic organization. Joint action and coordinated participation are highly desirable.

An individual or group from one of these organizations might provide the initial spark to start an institute or might be the spearhead which carries an institute to its successful conclusion.

What is the rôle of the sponsoring group?

A group sponsoring an institute must assume the responsibility for planning, organizing and carrying out the program. This it may do by delegation of authority to a

committee composed of representatives from several groups; it may be accomplished by retaining complete control within the organization and setting up a planning and executive unit for the administrative function. An organization may sponsor an institute solely by lending its name for prestige purposes. However, some group must assume the actual leadership and responsibility for performing the many and difficult tasks which precede an institute.

What is the rôle of the state hospital agency in planning?

The state agency which administers the Hospital Survey and Construction Act may assume primary control of an institute on hospital problems or it may act in an advisory capacity to another organization which has agreed to sponsor the program. If the latter situation exists, then the state agency should cooperate to the full extent, offering its staff members as consultants and speakers and assisting in every possible way. This position furnishes an excellent opportunity for promoting understanding and coordination

among the various hospitals, civic groups, other participating organizations, and the official state hospital agency.
What place have the individual hospitals in planning?

All hospitals, whether long established or new, in an area where an institute is being planned, should be vitally concerned with that planning. They are the backbone of such a program and their enthusiasm and active cooperation are necessary for success. These hospitals are a natural source of speakers on specific subjects, can furnish discussion leaders and other assistance for the smooth functioning of an institute. They must assist in defining problems and guide the approach to answering their most urgent needs. You must learn where your problems lie before you attempt to find their solution.

What is the place of community groups in planning?

A number of other community organizations can be of real help in planning an institute. As co-sponsors they can (through the use of their names) lend prestige, arouse interest, obtain publicity, provide voluntary help, furnish an introductory speaker, help arrange for a meeting place and probably provide much needed funds.

Frequently civic clubs welcome an opportunity to assist in such worthwhile projects. Allied health organizations, such as the tuberculosis, cancer and heart associations, are

willing and able to lend a helping hand when properly approached.

What is the place of the university in planning?

Most universities and colleges are interested in the promotion of extension courses in adult education. Opportunities to assist in projects in the hospital and health field find ready acceptance by such institutions. An organization sponsoring an institute on hospital problems would be wise to take advantage of the experience that would be available from a professional educational source in organizing and planning.

Methods, techniques, procedures and organizations are areas where the educational institution can assume leadership. In some instances the college might provide the physical facilities for the institute. The atmosphere alone would tend to stimulate the educational activity.

Smooth functioning depends on efficient organization and careful consideration of detail. This is no less true in promoting an institute than in operating a hospital. The following sections give procedures and methods which have proved successful in the conduct of previous institutes. The experience already gained is here made available to all in the hope that it will prove of benefit in continuing a task which is believed necessary for progress in the administration of our ever growing volume of hospitals.

Section I

PLANNING THE INSTITUTE

Planning an institute on hospital problems brings forth the same problems as planning any other type of educational program. The degree of success of the institute depends greatly on careful attention to the details which will effect the smooth functioning of the institute when it gets under way.

Some of the other factors which must be considered are:

1. ATTENDANCE

How many should attend?

Experience indicates that there should be no limit set on the number of registrants who will be accepted for attendance. A minimum of 25 might be established as the smallest group worthy of the effort required. A number of institutes in the past have had between 80 and 100 registrants with no apparent loss of effect. Above this number active individual participation in the sessions might be limited.

2. LOCATION

Where will the sessions be held?

It is necessary to make an early choice of city where the institute will be held. The building and the meeting room are likewise matters of early concern.

Is the chosen spot readily accessible?

The city must be accessible by the usual forms of transportation from all locations in the area from which registrants will come. The building must be conveni-

ently located within the city, easily reached by public transportation.

Will living accommodations be adequate?

Adequate living accommodations for faculty and registrants are a necessity. "Adequate" means that the rooms are comfortable, economical and conveniently located to the meeting place.

Are satisfactory eating facilities available?

Good meals, reasonably priced, should be available close by. Facilities for the noon meal should be such that the time allowed between sessions is sufficient.

3. FACULTY AND AGENDA

Who will coordinate the sessions?

While the organizing and planning of an institute is usually a committee effort, the conduct of the meetings should be the responsibility of one person (the coordinator) in order to ensure smooth operation. Selection of this individual is important because the success or failure of the institute may hinge on his ability as a leader.

Who will "chair" each session?

In addition to the over-all chairman or coordinator, each session should be the responsibility of one person who will be chairman for that meeting. Here again, the qualities of leadership are important to success of the sessions.

Who will lead the discussions?

If the chairman has outstanding knowledge of the particular subject to be discussed at a session he could well lead any discussion. However, it will be desirable frequently to have someone other than the chairman lead the discussion. This will introduce a fresh point of view and thus stimulate a livelier discussion. A broad knowledge of the immediate subject area is a necessity in either case as is the ability to direct a discussion group tactfully.

What is the source of speakers to present the basic material for each session?

Primary source of speakers at an institute is the local group of experienced hospital administrators and department heads who, being familiar with the problems peculiar to the area, are best able to present the needed material. Consultants on the staff of the state agency may also be called on as capable speakers and if possible regional or national personalities in the hospital field should be secured.

What other people are available and how may their abilities be used?

Most regions are fortunate in having people who are well versed in specialized areas of the hospital field. Utilization of these competencies in any way that they can be brought actively into the institute program will definitely increase its value to all who attend. Opportunity should certainly be given these resource people to express their views and ideas during the course of the discussions.

What is the procedure for establishing program content?

In the following sections of this publication a comprehensive group of subjects is organized into sessions for an institute. Each of these has been used successfully and will furnish the basis on which to build an institute on hospital problems. Planning should not be limited to these alone. The emphasis on particular phases of hospital operation should be determined from the local situation in each instance. Each hospital in the area covered by the institute should be a source of information on which to determine the program content. It is their problems which must be solved, not some hypothetical questions. The session outlines contained herein are for guidance and if found to apply locally, will be helpful.

4. ADMINISTRATION

How many days will the institute require?

It has been found that by careful planning of content and judicious timing, an institute on hospital problems may be completed in three days with reasonable chance of success. While the A.H.A. normally schedules institutes to last five days and this increase in time does have advantages, the lesser time is suggested as desirable in order to attract registrants from smaller institutions which might find the longer schedule a burden.

How long should each session last? How many sessions per day?

Experience with institutes indicates that sessions of about an hour per subject are most satisfactory. This allows from 20 to 30 minutes for material presentation, and from 30 to 40 minutes for discussion. With breaks in schedule for lunch and so forth six sessions per day can be managed easily. Night sessions may be added if desired but these should be relatively brief and not tiring to the participants.

How will attendance records be kept?

Only simple attendance records are necessary. The easiest method of checking attendance is to pass around a paper for all present to sign. This is later checked against an alphabetical list of registrants.

Who will be in direct charge of arrangements?

One person should be delegated the responsibility for arranging and carrying out the details of accommodations, meeting room, registration and the many other administrative particulars which will arise. Secretarial and clerical assistance is a necessity. Correspondence and other paper work will be sufficient to warrant the assignment of such personnel before, during and after the institute. Duplicated material will have to be prepared and distributed and this will require personnel and equipment.

5. PUBLICITY

How can interest in the institute be stimulated?

It is important to recognize and capitalize on the tremendous interest in better patient care. Suitable publicity will stimulate enthusiasm for the institute and be reflected in increased attendance. Announcements alone are not sufficient. Tell the whole story of the institute and get this information to the people you wish to attract. Get it to them early enough so they can make their plans to attend. The best planned institute, offering the utmost in content, cannot succeed unless the people who can derive the greatest benefit are given an opportunity to attend.

What about news releases during the institute?

The general public, too, is interested today in all phases of health. An organized campaign, with definite policies, will build public interest in your institute. Procedures for issuance of press releases and proper distribution should not be overlooked. Designate one person to handle this phase of the institute to forestall confusion and assure the type of publicity you want.

6. FINANCING

What will the expenses be and how will they be met?

Expense items for an institute include an impressive list from salaries, transportation and housing to equipment, supplies and miscellaneous services. Fortunately, only a small portion of the total cost involves the outlay of cash. Normally, it is not necessary to hire personnel to assist in planning or carrying out the institute. Office

help is usually assigned from the sponsoring agency. Office space is obtained on the same basis but it may be necessary to rent the meeting room if adequate space is not available without cost. Expenses incurred by the faculty for travel may be a big item if arrangements to compensate them otherwise are not possible. Printing and postage are definite expense items for which allowance must be made. Registrants are, of course, responsible for their own expenses.

Funds to promote an institute may be provided by the sponsoring group or covered by a fee for registration. A.H.A. and A.C.H.A. institutes are financed through registration fees as are also those held by the Ohio State Hospital Association. Usually no fees are

charged for those sponsored by government agencies. They are financed from the agencies' own funds.

It may be seen from these questions that the detail necessary to plan successfully for an institute consumes time and thought. Many additional details will be brought to mind as planning progresses. Obviously no manual can include everything that might arise. Local conditions and other factors make this impossible. However, it is thought that the foregoing suggestions will furnish a basis on which to plan.

As stated before, time and thought are essential. The following "time schedule" will indicate, in general, the sequence to be followed. The result should be an institute which runs smoothly and accomplishes its purpose.

TIME SCHEDULE

Prior to the Institute

90 days

Approximately three months before it is desired to hold an institute an organizational meeting should be called. At this time the main items to be considered are:

1. *Sponsorship*—A clearcut understanding of what group will accept responsibility for sponsoring the institute.
2. *Scope*—A determination of the general subject areas that will be included in the institute program.
3. *Location*—A decision as to the city and perhaps the site within the city where the institute may be accommodated, taking into consideration the facilities that will be needed in addition to an adequate meeting room.
4. *Finance*—A determination of how much money will be necessary and what the source of such funds will be.
5. *Committee Chairmen*—The appointment of competent persons to head up the various facets of planning for the institute.

60 days

At least two months prior to the date set for the institute, a planning and promotional meeting should be held at which the various committee chairmen should coordinate their activities. The choice of faculty should be made and the agenda begun. Some of the administrative problems appear and arrangements for announcements, publicity, space reservations and registration procedures must be worked out.

30 days

No less than one month prior to the institute date a progress and details meeting will be necessary to learn whether the plans are progressing properly. Agenda must be completed.

Arrangements should be made for the following:

Living accommodations for faculty and registrants.

Display material needed for the various sessions.

Attendance certificates (when used).

Stationery supplies—pencils, note pads, etc.

Equipment—projectors, screen, blackboard, chalk and erasers, public address system, recording facilities (when desired).

Other administrative details which will arise.

15 days

Two weeks before the institute a final meeting should be held. At this time the program should be ready for distribution and committee reports should indicate that all details have been adequately covered. Instructions to registrants should be mailed out and a review made of all phases of planning to ascertain that nothing of importance has been overlooked. Final instructions to the administrative staff should be issued.

First day of Institute

If plans have been properly laid, the opening day of the institute presents only administrative problems. A final day-before check should have disclosed that the meeting room with the necessary equipment, furnishings and supplies is ready. When the registrants arrive they must be checked in and accounted for. The faculty and participants must be welcomed and all who attend should receive the impression that the institute has been planned efficiently. First impressions are important, and smooth functioning at the outset is a stepping stone to a successful and worthwhile institute.

Subsequent to Institute

The final day of the sessions should include a period when each registrant is given the opportunity to submit his evaluation of the subject matter and material he has received. These opinions should be tabulated and studied.

Shortly after the institute, letters of appreciation for their help should be sent to the faculty and staff.

Outstanding sessions of the institute should be recorded and, if of general interest, submitted for publication. A general brief summary of the sessions should be released to the hospital journals for its news value.



The following agenda shows how an institute program might be set up. It is based on a three-day session and covers the entire range of subjects included in this publication.

Attention is directed to the timing of sessions and to the arrangement of subjects in a logical and interest sustaining sequence.

A presiding officer is needed for each of the three days. For one thing, this gives official recognition and honor to capable persons. Also, it spreads the burden of responsibility.

Speakers and discussion leaders' names, titles and addresses should be shown.

The final session should constitute a summary of the entire program. Time should be allotted for the attendants' written evaluation of the program, although these evaluations need not be identified. These comments should be carefully analyzed later to measure the success of the institute.

If a certificate of attendance is to be presented, it is a logical conclusion for the institute.

INSTITUTE ON PROBLEMS OF THE NEW HOSPITAL

May 3 through May 5, 19....

Wednesday, May 3

Presiding:

9:00 REGISTRATION

10:00 INTRODUCTION AND SCOPE OF THE INSTITUTE

Speaker:

Discussion Leader:

11:00 RECESS

11:15 ORGANIZATIONAL RELATIONSHIPS OF HOSPITAL SERVICE

Speaker:

Discussion Leader:

12:15 LUNCH

1:30 HOSPITAL AND THE LAW

Speaker:

Discussion Leader:

2:30 FINANCING

Speaker:

Discussion Leader:

3:30 RECESS

3:45 ACCOUNTING

Speaker:

Discussion Leader:

Thursday, May 4

Presiding:

9:00 MECHANICAL SERVICES

Speaker:

Discussion Leader:

10:00 HOUSEKEEPING AND LAUNDRY

Speaker:

Discussion Leader:

11:00 RECESS

11:15 MEDICAL RECORDS

Speaker:

Discussion Leader:

12:15 LUNCH

1:30 LABORATORY, X-RAY, PHARMACY

Speaker:

Discussion Leader:



2:30 NURSING SERVICE STAFFING

Speaker:
Discussion Leader:

3:30 RECESS

3:45 ESTABLISHING NURSING SERVICE IN NEW HOSPITAL

Speaker:
Discussion Leader:

Friday, May 5

Presiding:

9:00 ADMITTING

Speaker:
Discussion Leader:

10:00 FOOD SERVICE

Speaker:
Discussion Leader:

11:00 RECESS

11:15 SAFETY

Speaker:
Discussion Leader:

12:15 LUNCH

1:30 PUBLIC RELATIONS

Speaker:
Discussion Leader:

2:30 COORDINATION

Speaker:
Discussion Leader:

3:30 RECESS

3:45 SUMMARY AND EVALUATION

The session outlines and illustrative material which follow are for the most part self-explanatory.

The opening session is introductory; it serves to set the stage for what is to follow. The slogan, "Better Patient Care," is used as the theme of the institute and becomes the pivot point around which the other subjects should revolve.

The panels, whose original size is 30 by 44 inches, are done in appropriate colors and were designed to focus attention on the fundamentals of each subject. The use of similar illustrative material is strongly recommended.

It is also suggested that copies of the outlines be distributed to each participant. The usual practice of releasing duplicated copies of complete speeches places the emphasis on one person's opinion, the writer of the speech. To gain the most value from an institute, the emphasis should be on the points brought out in discussion. These are most likely to make a lasting impression on the participants.

INTRODUCTION

I. Goal—"Better Patient Care"

II. Approach to "Better Patient Care"

- A. Clinical
- B. Administrative
- C. Educational

III. Institute on Hospital Operation

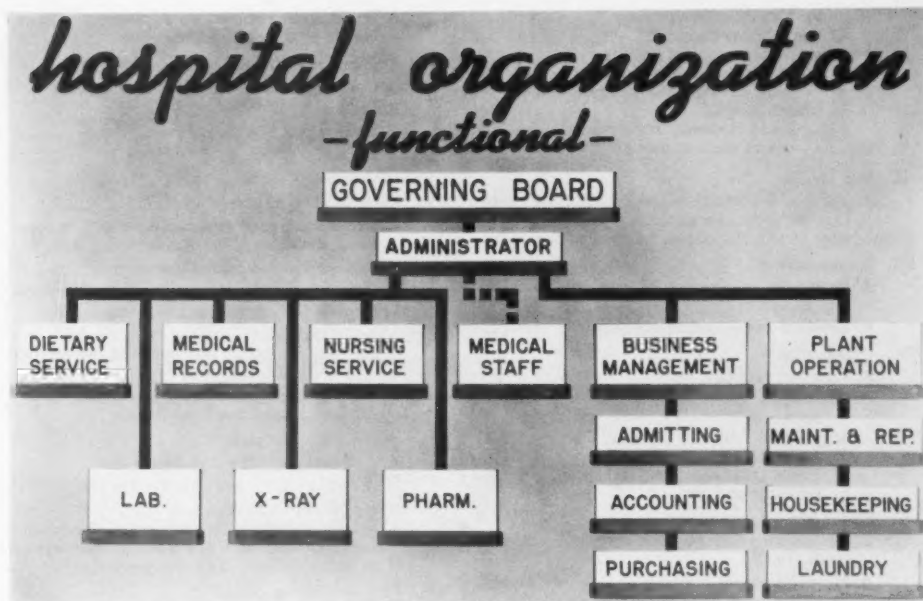
A. An educational technic

- 1. Based on the presentation of clinical and administrative problems as they relate to the opening of a new hospital and its continued operation

B. The program

1. Basis

- a. Planned to present certain problems that determine whether the hospital will open its doors to the public on time; also to



- assist the hospital to provide the best patient care as effectively as possible.
- b. Based on principle that recognition of problems is helpful; presentations on subject matter are keyed to an administrative approach; technical material is based on the text, "Elements of Hospital Operation." (Present text and explain use.)
2. Content
 - a. Areas of consideration—(check program)
 3. Organization
 - a. Permits coverage of problems with as little overlapping as possible.
 - b. Each section presented is a complete entity in itself.
 - c. Not a chronological presentation in terms of when things happen.
 - d. Each major subject has been assigned a one-hour session.
 - e. First part given over to presentation of prepared material (20-30 minutes).
 - f. Second part given over to discussion of subject matter presented and any additional problems.
 - C. Success of the institute depends on
 1. Extent of group participation
 2. Group's evaluation and comments

FUNCTIONAL HOSPITAL ORGANIZATION

Introduction

- I. Efficient organization depends upon sound community planning.
- II. The purpose to be served is of major importance

in establishing the administrative framework of the hospital.

- A. A business organized for profit would best be served by a single executive with a great deal of authority, coldly exercised.
 - B. An organization set up with service to the community as a principal object must deal with the general public with a more subjective and understanding approach.
- III. It is difficult to operate a hospital not for business ends but by business means.
 - IV. Definition of areas of authority in the hospital is complicated, requiring constant thought to its purposes.
 - A. Hospital does not give or sell medical care.
 - B. Hospital makes facilities available for staff to give medical care.
 - C. Point where making facilities available and the application of these tools is difficult to determine.
 - D. Extreme care in the choice of professional personnel to whom facilities will be available is a necessity.
 - V. Major elements of the administrative structure
 - A. Governing board
 - B. An organized medical staff
 - C. The chief executive officer
 - D. Departmentalized personnel

The Governing Board

- I. Composition
 - A. Varies by type of hospital
 1. Nonprofit community hospital
 - a. Wholly and legally responsible for policies, property and services

- b. Usually self-perpetuating
- 2. Government hospitals
 - a. Administered by appointed officer responsible to some higher officer in a department having many other functions.
- 3. Church hospitals
 - a. Board is usually remote—not advantageous to the community
- II. Size
 - A. Varies with community and its needs. Sufficiently large to have major elements represented. Not so large as to make smooth functioning impossible.
- III. Representation
 - A. From wide cross-section of responsible community groups.
 - B. Members from medical staff open to criticism.
- IV. Organization
 - A. President, secretary, etc.
 - B. Committees
 - 1. Finance
 - 2. Joint advisory
 - 3. Professional
 - 4. Public relations
 - 5. Buildings and grounds
- V. Duties and responsibilities
 - A. Determines policies with relation to community needs.
 - B. Maintains proper professional standards through direct legal responsibility for exercise of due care in appointment of medical staff.
 - C. Coordinates professional interests of the hospital with administrative, financial and community needs.
 - D. Directs administrative officer to carry out policies.
 - E. Provides adequate financing and control of expenditures.

The Medical Staff

- I. Quality of patient care depends on individual medical staff members.
 - A. Organization of staff a necessity.
- II. Functions
 - A. Advises governing board in its formulation of policies and regulations relating to professional care of the patient.
 - B. Fosters within staff a spirit of professional cooperation which will ensure highest grade of medical service to the patient.
- III. Active staff
 - A. Prepares medical policies.
 - B. Assumes responsibility for indigent patients.
 - C. Participates in educational progress of the hospital.
 - D. Formally organized with specific responsibilities delegated to individuals or committees.
 - E. Separated into sections, such as medicine, surgery, obstetrics, according to qualifications.

The Executive Officer

- I. In direct charge of the hospital
 - A. Represents and is responsible to governing body.
- II. Responsibility with matching authority delegated by governing board

- A. Board depends entirely on administrator to carry out its expressed policies.
- III. Administrator responsible to
 - A. Governing board
 - B. Patient
 - C. Medical staff
 - D. Hospital Personnel
 - E. Community
- IV. Responsibility to governing board
 - A. Keeps board fully informed on results of operations, methods and details used.
 - B. Advises board in formulation of policy.
 - C. Interprets board's policies in carrying them out.
 - D. Prepares budget for board approval showing:
 - 1. Estimate of receipts and expenditures.
 - 2. Need for income to supplement that received from patients.
 - E. Fund raising is a board responsibility and should not be delegated to administrator.
- V. Responsibility to patient
 - A. Assurance of safety and proper care.
 - B. Administrator is personification of the hospital.
- VI. Responsibility to medical staff
 - A. Provide and maintain facilities, equipment and assistance in order that patient may be restored to health quickly, safely and pleasantly.
- VII. Responsibility to personnel
 - A. Provide framework of organization and proper physical facilities to enable them to carry out their assigned duties.
 - B. Coordinate and correlate their efforts.
 - C. Provide decent working conditions.
 - D. Compensate adequately and furnish an incentive for increased efficiency.
- VIII. Responsibility to community
 - A. Keep pace with new developments to assure quality of services maintained by:
 - 1. Cooperating with other hospitals and health agencies.
 - 2. Participating in national and regional hospital organizations.
 - 3. Utilizing progressive ideas which are developed.
 - B. Keep community informed that its needs are provided for to assure its continued support and patronage.

Departmental Personnel

- I. Elemental division
 - A. Professional care of patient.
 - B. Administration
- II. Average small hospital divisions
 - A. Professional care of the patient
 - 1. Nursing service
 - 2. Medical records
 - 3. Dietary service
 - 4. Laboratory
 - 5. X-ray
 - 6. Pharmacy
 - B. Administration
 - 1. Business management
 - a. Admitting
 - b. Purchasing
 - c. Accounting

LEGAL & MORAL RESPONSIBILITIES



2. Plant operation
 - a. Maintenance and repair
 - b. Housekeeping
 - c. Laundry and linen
- III. Degree of departmentalization determined by size and program of hospital.
 - A. Divisions developed as required.
 - B. In large hospital rigid lines of supervision are a necessity.
 - C. Smaller hospitals operate on more informal basis, but regardless of size of plant employees must know to whom they are responsible.
 - D. Organization must be tailored to fit the specific hospital.
 - E. Necessary to define functions and relations of each position clarifying the interdependency that all departments in hospital bear to one another.

Conclusion

- I. Functional organization only as strong as the individuals who conceive and administer it.
- II. Daily practical application of the principles of good management necessary to achieve goal.

Some Legal Aspects of Hospital Administration

- I. Nature and scope of the subject

Subject limited to an over-all view rather than specifics under state law.
- II. Organization and incorporation of hospitals together with their tax status
 - A. Public or governmental institutions—separately organized or units of departments or agencies.

- B. Private or nonprofit hospitals—voluntary nonprofit corporations.
- C. Proprietary hospitals—business corporations.
- III. Governing board
 - A. Organization
 1. In governmental institutions
 2. In nonprofit corporations
 - B. Responsibilities from a legal standpoint
- IV. Administrator
 - A. Appointed by and represents board.
 - B. Legal responsibilities almost identical with those of the board.
- V. Essential documents prior to opening
 - A. Necessity for complying with state licensing laws and local regulations.
 - B. Obtaining narcotic permits, laboratory licenses, and miscellaneous essential documents.
 - C. Requirements of American College of Surgeons helpful in establishing a new institution on a sound legal basis.
- VI. Medical staff
 - A. Selection and organization
 1. Legal aspects on selection
 2. Establishment of regulations
 - B. The problem of the hospital practicing medicine
- VII. Nonmedical staff
 - A. Responsibility for selection and amount of care required.
 - B. Social Security, Unemployment Compensation, Workmen's Compensation and miscellaneous problems relating to the employed staff.
- VIII. Establishing specialized procedures prior to opening

- A. Medical records—their necessity from a legal standpoint, admissibility in evidence, and privilege of the patient.
 - B. Admission and discharge policies and procedures.
 - C. Consent to surgery—the general procedures, emergency and minor precautions.
 - D. Miscellaneous requirements in cases of autopsy, fractures, birth registration, mental cases, "police cases."
- IX. Liability for injury to others—wrongful acts (torts)
- A. Governmental hospitals—official and nonofficial acts of public servants.
 - B. Nonprofit hospitals—various applicable rules.
 - C. Explanation of liability based on performance of either professional or nonprofessional acts—extent of liability.
 - D. Summary of the problem and nature of questions of fact usually in issue.
- X. Liability for maintenance of a safe hospital
- A. Liability to patients and visitors.
 - B. Liability to staff and employees.
- XI. Hospital insurance problems
- A. Nature and extent of the problem.
 - B. Types of policies, coverage, exceptions, settlement.
 - C. Recommendations.

FINANCING

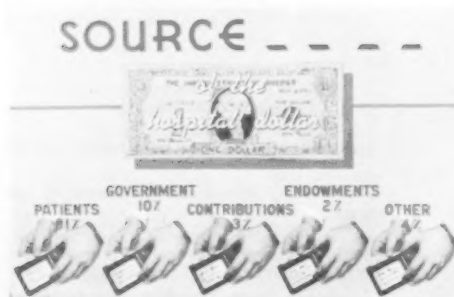
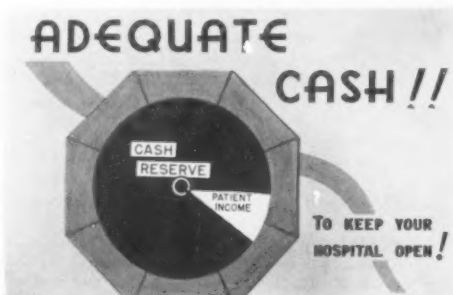
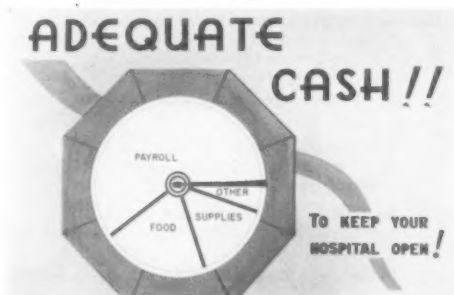
- I. Why is financing important to the hospital?
 - A. At the time of opening
 - B. During its continued operation and growth

II. Where does the hospital dollar come from?

- A. For opening
 - 1. Reserve
 - a. Estimate of operating deficit (difference between hospital expense and income)
 - b. Need for reserve for opening
 - (1) Readiness to serve
 - (2) Occupancy relationship
 - (3) Pay roll and supply requirements during early stage of operation
 - (4) Estimate of reserve (three months' expenses one quarter of operating estimate)
 - c. Sources of reserve
- B. For operation
 - 1. Patients (approximately 80%)
 - 2. Other (approximately 20%)
 - a. Government
 - b. Contributions
 - c. Endowments
 - d. Miscellaneous

III. Where does the hospital dollar go?

- A. Administration—9%
- B. Dietary service—17%
- C. Plant operation—18%
 - 1. Laundry
 - 2. Heat, light and power
 - 3. Maintenance and repair
 - 4. Housekeeping
- D. Nursing—23%
- E. Other professional services—25%
 - 1. Medical and surgical
 - 2. Medical records
 - 3. Laboratory
 - 4. X-ray



5. Physical therapy
 6. Pharmacy
 - F. Miscellaneous—8%
- IV. Administrative aspects that affect financing
- A. Determination of charges
 1. Usefulness of budget
 2. Relation to insurance aspect of community
 3. Relation to neighboring hospital charges
 4. System of charges
 - a. All-inclusive rate
 - b. Partially-inclusive rate
 - c. Unit of service
 - d. Formula of reimbursement for contract relations
 - B. Establishment of contract relations
 1. With nongovernmental agencies
 - a. Blue Cross
 - (1) Relative importance of Blue Cross plans
 - (2) Methods of paying hospitals
 - (3) Adequacy of payments
 - b. Commercial insurance
 - (1) Varied benefits
 - (2) Methods of payment
 - c. Other
 2. With governmental agencies
 - a. Payment for indigent cases
 - (1) Necessity of full cost payments for care
 - (2) Determination of indigency clearly stated
 - b. Workmen's Compensation
 - c. Veterans
 - d. Children's Bureau programs
 - e. Vocational rehabilitation

- C. Establish credit and collection policies
 1. Advance payment on admission
 2. Periodic payments during hospitalization
 3. Acceptance of wage assignments
 4. Follow-up on delinquent accounts
- D. Establish allowance and discount policy
 1. Medical staff
 2. Hospital employees
 3. Clergy and others

ACCOUNTING

- I. Introduction
 - A. Good accounting means "Records."
 - B. Accounting records must be justified by need they fill.
- II. Minimum bookkeeping records
 - A. Check book—its limitations.
 1. Expenses not separated on a functional or departmental basis.
 2. Provides no internal control of cash.
 3. Provides no method for accumulating building and equipment costs.
 4. Provides no method for statistically measuring services rendered by each department.
 5. Provides no basis for comparing one year's operations with another.
 6. Tedious and time-consuming task to analyze each check to determine type and amount of each item.
 7. Provides no accurate method for accumulating individual employee's earnings.
 - B. Deposit book—its limitations
 1. Provides no ready means for segregating income by department, function or source.

GOOD ACCOUNTING MEANS

RECORDS CORRELATING STATISTICS AND ACCOUNTING
ELIMINATION OF UNNECESSARY WORK
CASH SAFEGUARDS
OFFERS MAXIMUM INFORMATION WITH MINIMUM COST & EFFORT
READY PREPARATION AND VERIFICATION OF PATIENTS' ACCOUNTS
DAILY SUMMARY OF BUSINESS TRANSACTIONS
SUPPLIES BASIS FOR MEASURING STANDARDS OF PATIENT CARE AND ESTABLISHING HOSPITAL RATES

INADEQUATE RECORDS

DEPOSIT SLIP
 CHECK
 RECEIPT

MINIMUM CASH RECORDS

ADMITTING RECORDS
 CASH RECEIPTS JOURNAL
 CASH DISBURSEMENTS JOURNAL

MINIMUM ACCRUAL RECORDS

ADMITTING RECORD
 CASH RECEIPTS JOURNAL
 CASH DISBURSEMENTS JOURNAL
 CHARGE SLIPS
 PATIENTS' LEDGER
 PETTY CASH BOOK
 GENERAL LEDGER
 EMPLOYEE EARNINGS RECORD
 PAYROLL JOURNAL
 VOUCHER REGISTER
 GENERAL JOURNAL

2. Makes it impossible to establish the usual accounting and administrative controls.
3. Cannot readily provide management with current financial information relating to total income or departmental income.
4. Would provide no statistical data so necessary in analyzing income.

C. The receipt—its limitations

1. Provides no method for control over cash receipts.
2. Lacks one important element of good accounting, namely, a department or functional breakdown of income by sources.
3. Provides no accurate basis for verification of cash receipts.
4. Does not provide for the accumulation of credits to individual patient's accounts as it would be necessary to examine all receipts to find out what amounts have been paid.
5. Such a method places the records on the cash basis which is not an accurate basis for computation of total income or expense for any period.

III. Cash basis

A. The admitting record—its limitations

1. Serves as a record for initiating services to patients but without a register of inpatients it is not possible to segregate, for statistical use, the services or accommodations provided each patient, or readily to accumulate patient statistical data, such as classification by residence, by financial relationship, by contractual relationship.
2. Without special service charge slips, the accounting office must rely solely on the floor nurse to record all services to patients, thereby leaving too much to one person's responsibility and perhaps to the memory of that person.

B. Cash receipts journal—its limitations

1. Provides no method for recording patients' charge payments; in fact, such a journal for all receipts places the accounting records on the cash basis.
2. Provides no method by which departmental income can be readily accumulated for each month of the fiscal year.
3. Lacks elements of good accounting control over cash and other liquid assets.
4. Provides no basis for charging patients accurately for room, board, routine and special services.
5. Does not provide the statistical data required to measure units of service.
6. Makes the task of arriving at patients' balances a tedious and time-consuming one.
 - a. Under such a system it becomes necessary to thumb through the pages of the cash receipts journal to ascertain what payments have been made on a patient's account.
7. Provides no petty cash fund nor a method for controlling cash disbursements, if made from cash received from patients before it is deposited in the hospital bank account.
8. Does not permit the taking of a trial balance and makes it difficult, if not impossible, to prepare accurate financial statements.

C. Cash disbursements journal—its limitations

1. Provides no method for accumulating monthly expenditures on a departmental or functional basis.
2. Renders the task of preparing employees' records of earnings far more difficult than if employees' earnings records were prepared currently at the time pay rolls are prepared.
3. Provides no method for charging employees with authorized deductions from their salaries.
4. Adjustments for errors and for depreciation, bad debts, and so forth cannot be made since no general journal for making such entries would be provided.
5. Purchases on open account could not be recorded as no accounts payable are set up under a cash basis of accounting.

IV. Additional records are needed to establish an accounting system on the accrual basis.

A. The minimum records for an accrual system are:

1. Admitting record
2. Cash receipts journal
3. Cash disbursements journal
4. Charge slips
5. Patients' ledger
6. Petty cash book
7. General ledger
8. Employee earnings record
9. Pay roll journal
10. General journal
11. Voucher register

PLANT OPERATION, MAINTENANCE AND REPAIR

I. Relationship to patient care

- A. Equipment must function perfectly at all times.
- B. Sanitary aspects: Faulty equipment may spread disease.
- C. Safety aspects: The chief engineer is second only to the administrator in his responsibility for the maintenance of safety.

II. Qualifications of the chief engineer

A. Basic prerequisites

1. Emotional stability
2. Independent judgment
3. Supervisory ability
4. Ability to work with others

B. Training and experience

1. Licensed where required
2. General mechanical and building trades background
3. Good knowledge of pressure vessel operation and maintenance

III. Operation of the department

A. The chief engineer is recognized as the head of a major department.

B. Under the supervision of the chief engineer may be the following:

1. The maintenance, repair and operation of all equipment, machinery and distribution lines concerned with the following:
 - a. Steam and hot water
 - b. Plumbing (including waste disposal)
 - c. The electrical system (power and lighting, including emergency lighting)

mechanical services ..



- d. Fire detection, prevention and fire fighting methods and devices
 - e. Carpentry (including furniture repair)
 - f. Painting and decorating
 - g. Vertical transportation equipment (elevators, dumb-waiters)
 - h. Communication and mechanical messenger systems
 2. Grounds maintenance and landscaping
 3. Safety
- C. Purchase and installation of new plumbing, electrical or mechanical equipment for all departments to the extent that:
1. Requisitions are routed to the chief engineer for his comments
 2. Installation is under the supervision of the chief engineer
- D. Fuels are selected and purchased only after conference with the chief engineer.
- E. Chief engineer is the hospital fire marshal.
- F. Chief engineer is member of hospital safety board and safety inspection team.
- G. Chief engineer accompanies all outside inspectors when they make their rounds.
- H. Set up a work order system and provide centralized control over it. For example:
1. Only emergency jobs done without written work order. Written order follows.
 2. Chief engineer routes orders and makes follow-up.
 3. Accurate cost records are maintained showing cost per job and cost per department.
- I. Devices for effecting fuel economy are provided.
- J. There are written preventive maintenance schedules for each piece of mechanical or electrical equipment.
- K. Chief engineer instructs department heads in proper use of equipment to lessen maintenance costs.
- L. The chief engineer consults with electric power company engineers periodically to ascertain that there is adequate illumination and power without waste.
- M. Equipment and supplies are standardized as much as possible so as to reduce inventories of repair and replacement parts.
- N. The chief engineer maintains the permanent files of manufacturers' operating and maintenance instructions and blueprints.
- O. There is an established routine for notifying each affected division of the hospital in advance of the voluntary suspension of any utility service.
- P. The chief engineer maintains liaison with other engineers in the area (power plants, manufacturing and machine shops).
- Q. The chief engineer is provided with adequate office space and clerical assistance.
- R. Consider advantages and disadvantages of contract repair and maintenance service for such categories of equipment as elevators, office equipment.

Who Really Takes Care of the Patient?

Study of nursing hours in nine New Jersey hospitals

THREE and one-half hours of nursing care per patient each day is an accepted formula for determining the distribution of nurses in relation to patients in hospitals, or so many of us have assumed. Nine members of the Assistant Hospital Administrators Society of New Jersey examined patient care in their hospitals to test the applicability of this venerable doctrine. Beginning this study in January 1950, we have since analyzed and assessed our findings and developed a number of interesting statistics.

The more specific purposes of the study were to determine how many hours of nursing care the patient is getting, to analyze these hours in terms of time expended by graduate, student and auxiliary personnel, and to examine the distribution of care in the hospital by shift, by day and by week.

In other words, the patient was the chief object of concern throughout this study, and in our examination of our respective hospitals, we asked ourselves the following questions: How many hours of care is the nursing staff giving

the patient? Does the patient receive the same amount of care each day or does it vary from one day to the next? What is the allotment of this care by shift? Are graduate nurses providing the greater proportion of the care or is this being given by student nurses and auxiliary staff persons? What about week-end coverage? Who comprise the nursing staff at night?

Nine voluntary general hospitals participated. These range in size from 103 beds to 447 beds. Facilities and location of these hospitals differ considerably. All but one has a school of nursing.*

Because New Jersey is a small state

*A table of descriptive data about the hospitals is contained in Exhibit 1.

(45th in size), data from nine hospitals should present a fair cross-section. As a matter of fact, this is probably the case. The greatest distance separating any two participating hospitals is 90 miles. Hospitals "A" through "E" are located within the suburban limits of large metropolitan areas, one near Philadelphia, four within 20 miles of New York City. Hospitals "F" through "I" are scattered throughout the central section of New Jersey from the Atlantic Coast to the Delaware River. One is in an important industrial community. The large "medical center" type of hospital is not represented, nor is there any bona fide rural hospital in the group, neither of which can be described as typical of New Jersey.

Recognizing these and other acceptable differences in the nine hospitals, we nevertheless made every effort to achieve a high degree of homogeneity of data. Thus, the following points are significant in the structure of the study:

1. We considered the hours of care given to patients in patient areas only. Auxiliary services, such as operating room, delivery room, and central supply room, were excluded.

The authors are members of the Assistant Hospital Administrators Society of New Jersey, which conducted the study they are reporting here.—Ed.

Exhibit 1—Study of Medical and Surgical Adult Patient Care—Week of Jan. 22-28, 1950

Hospital	A	B	C	D	E	F	G	H	I
bed capacity (only units in study).....	262	230	197	169	76	173	164	159	59
Adjusted census:									
Weekly average.....	221	222	156	131	76	140	140	143	39
Highest day*.....	219	204	154	125	63	140	145	...	35
Lowest day*.....	233	210	152	138	78	149	141	...	45
Number of medical and surgical nursing units in study	8	9	7	5	2	5	9	6	3
Average size of unit.....	33	28	28	34	38	35	18	26	20
Enrollment—School of Nursing									
Senior students.....	34	25	29	27	14	17	38	18	...
Junior students.....	39	21	28	30	21	23	24	30	...
Freshman students.....	...	...	...	...	...	...	...	...	...
Preclinical students.....	53	39	37	22	30	24	26	35	...
TOTAL.....	126	85	94	79	65	64	88	83	...
Central sterile supply†.....	Yes	Yes	Yes	Yes	No¹	Yes	No²	Yes¹	No
Postoperative recovery room†.....	No	No	Yes	No	No	Yes	No	No	No
Food service to bedside by dietary or nursing personnel†.....	N	N	N	D	N	N&D	N	N	D

*Highest and lowest days in hours of patient care—not census.

†Some trays and preparations are prepared in a limited degree by the nurse who is also in charge of the emergency room. This nurse was excluded from the study.

²Central dressing (or surgical supply) staffed by non-included auxiliary nursing personnel (1).

Exhibit 2—Study of Medical and Surgical Adult Patient Care—Week of Jan. 22-28, 1950
Hours of Care per Patient

Hospital		A	B	C	D	E	F	G	H	I
Full Day:	Weekly average.....	4.25	3.71	4.31	4.08	3.53	3.16	4.97	4.18	4.78
	Highest day.....	4.65	4.14	4.69	4.70	4.47	3.58	5.26	....	5.73
	Lowest day.....	3.93	3.49	4.11	3.70	2.53	2.90	4.69	....	3.85
7 a. m.—3 p. m.	Weekly average.....	2.39	2.27	2.55	1.94	2.13	1.88	2.64	2.64	2.37
	Highest day.....	2.68	2.64	2.91	2.30	2.72	2.26	2.87	....	2.90
	Lowest day.....	2.12	2.10	2.20	1.80	1.33	1.65	2.47	....	2.00
3 p. m.—11 p. m.	Weekly average.....	1.27	.95	.90	1.32	.89	.70	1.31	.81	1.46
	Highest day.....	1.36	.99	.88	1.50	1.05	.68	1.32	....	1.71
	Lowest day.....	1.08	.93	.97	1.10	.74	.70	1.22	....	1.14
11 p. m.—7 a. m.	Weekly average.....	.63	.49	.86	.82	.51	.58	1.02	.73	.95
	Highest day.....	.67	.50	.90	.90	.70	.64	1.07	....	1.12
	Lowest day.....	.56	.46	.94	.80	.46	.55	1.00	....	.71

Exhibit 3—Study of Medical and Surgical Adult Patient Care—Week of Jan. 22-28, 1950
Percentage of Care by Graduate Nurses

Hospital		A	B	C	D	E	F	G	H	I ^a
Full Day:	Weekly average.....	*	56.0	46.0	42.0	49.6	49.0	57.7	55.0	84.9
	Highest day.....	*	58.5	46.0	44.0	46.7	51.0	60.2	*	84.3
	Lowest day.....	*	54.0	44.0	40.0	59.1	44.0	64.6	*	89.0
7 a. m.—3 p. m.	Weekly average.....	52.7	52.3	51.0	44.0	59.2	49.0	62.5	44.0	85.5
	Highest day.....	60.3	53.0	50.0	47.0	54.2	50.0	65.1	*	84.5
	Lowest day.....	48.6	49.1	51.0	42.0	76.0	39.0	71.2	*	82.6
3 p. m.—11 p. m.	Weekly average.....	41.5	59.8	40.0	35.0	36.8	44.0	54.6	51.0	84.2
	Highest day.....	46.6	66.6	46.0	37.0	41.1	46.0	54.8	*	86.8
	Lowest day.....	38.3	61.5	41.0	38.0	46.6	28.0	59.2	*	92.3
11 p. m.—7 a. m.	Weekly average.....	14.1	65.3	44.0	49.0	30.4	55.0	49.9	75.0	84.8
	Highest day.....	19.4	71.4	41.0	50.0	27.2	58.0	53.8	*	80.0
	Lowest day.....	9.6	61.5	41.0	41.0	33.3	64.0	55.4	*	100.0

*Data absent or not homogeneous.

**No school of nursing.

Exhibit 4—Study of Medical and Surgical Adult Patient Care—Week of Jan. 22-28, 1950
Percentage of Care by Student Nurses

Hospital		A	B	C	D	E	F	G	H	I
Full Day:	Weekly average.....	*	6.2	8.0	17.0	20.0	18.0	15.6	19.0	**
	Highest day.....	*	2.4	6.0	18.0	21.6	10.0	14.1	*	**
	Lowest day.....	*	10.2	9.0	14.0	20.4	27.0	10.8	*	**
7 a. m.—3 p. m.	Weekly average.....	14.2	6.6	6.0	22.0	14.8	19.0	11.0	30.0	**
	Highest day.....	10.7	3.7	6.0	27.0	21.7	14.0	10.2	*	**
	Lowest day.....	10.8	11.9	10.0	16.0	8.0	36.0	5.5	*	**
3 p. m.—11 p. m.	Weekly average.....	19.1	3.2	11.0	19.5	28.6	22.0	17.8	10.0	**
	Highest day.....	21.0	—	6.0	16.0	23.6	8.0	17.3	*	**
	Lowest day.....	17.0	3.8	11.0	20.0	26.7	36.0	16.4	*	**
11 p. m.—7 a. m.	Weekly average.....	14.2	11.9	6.0	—	29.0	13.0	24.2	5.6	**
	Highest day.....	15.8	—	6.0	—	18.2	8.0	20.6	*	**
	Lowest day.....	9.0	15.4	6.0	—	44.4	9.0	16.7	*	**

*Data absent or not homogeneous.

**No school of nursing.

Exhibit 5—Study of Medical and Surgical Adult Patient Care—Week of Jan. 22-28, 1950
Percentage of Care by Auxiliary Personnel

Hospital		A	B	C	D	E	F	G	H	I
Full Day:	Weekly average.....	*	37.8	46.0	41.0	30.4	33.0	26.7	26.0	15.1
	Highest day.....	*	39.1	48.0	38.0	31.7	39.0	25.7	*	15.7
	Lowest day.....	*	35.8	47.0	46.0	20.5	29.0	24.6	*	11.0
7 a. m.—3 p. m.	Weekly average.....	33.1	41.1	43.0	34.0	26.0	32.0	26.5	26.0	14.5
	Highest day.....	29.0	43.3	44.0	26.0	24.1	36.0	24.7	*	15.5
	Lowest day.....	40.6	39.0	39.0	42.0	16.0	25.0	23.3	*	17.4
3 p. m.—11 p. m.	Weekly average.....	39.4	37.0	49.0	45.5	34.6	34.0	27.6	39.0	15.8
	Highest day.....	32.4	33.4	48.0	47.0	35.3	46.0	27.9	*	13.2
	Lowest day.....	44.7	34.7	48.0	42.0	26.7	36.0	24.4	*	7.7
11 p. m.—7 a. m.	Weekly average.....	71.7	22.8	50.0	51.0	40.6	32.0	25.9	19.4	15.2
	Highest day.....	64.8	28.6	53.0	50.0	54.6	34.0	25.6	*	20.0
	Lowest day.....	81.4	23.1	53.0	59.0	22.3	27.0	27.9	*	—

*Data absent or not homogeneous.

**No school of nursing.

2. Job classifications which provide nurses with more time for patient care were included. We included ward secretaries assigned to nurses' stations who answer the telephone and assist with record keeping. Similarly, volunteers, attendants or maids whose chief function is the care of patients were included. Hence, this is a study of the nursing care of the patient in a broad sense of the term rather than merely the number of hours expended by the nurse attending the patient.

3. Only adult medical and surgical patients were used in the study, so that the peaks and valleys in the census of the maternity and pediatric departments were avoided. It is also important that medical and surgical patients comprise the largest portion of the census of the hospitals surveyed.

4. We limited the survey to seven consecutive days in January and conducted it simultaneously in the nine hospitals. This encompassed week-end coverage and allowed an analysis of the weekly coverage as well as the days during which the greatest and least number of hours of care were provided.

5. We compiled not only the composite daily average, but separated the distribution between 7 a.m. to 3 p.m., 3 p.m. to 11 p.m., and 11 p.m. to 7 a.m. shifts. Likewise we computed the percentage of care provided by graduate nurses, student nurses and auxiliary personnel. Preclinical student nurses did not enter into the survey, because they had not completed basic classroom requirements and were not assigned to wards.

6. The census used throughout was the official census as of midnight of the preceding date. To eliminate the effect of private duty nurses, the census was adjusted downward to remove one patient from the census for each private duty nurse on duty each shift. Thus the adjusted census used in the computation of hours of care per patient is the official census minus the number of private duty nurses on duty during any particular shift.

7. The computation considered only the working hours of persons concerned. We took particular care to include any time nursing department supervisors devoted to patient areas. Thus, in some institutions the evening and night supervisors' time was devoted almost entirely to patient care. Where this affected medical and surgical patients this time was included. Administration time was excluded.

Percentage of Care by Graduate Nurses

	Highest Hospital	Lowest Hospital	†Per Cent of Variation
Full Day.....	57.7%	42.0%	37
7 a. m.—3 p. m.....	62.5%	44.0%	42
3 p. m.—11 p. m.....	59.8%	35.0%	70
11 p. m.—7 a. m.....	75.0%	14.1%	432

Percentage of Care by Student Nurses

	Highest Hospital	Lowest Hospital	†Per Cent of Variation
Full Day.....	20.0%	6.2%	223
7 a. m.—3 p. m.....	30.0%	6.6%	354
3 p. m.—11 p. m.....	28.6%	3.2%	794
11 p. m.—7 a. m.....	29.0%	0—	2900

Percentage of Care by Auxiliary Personnel

	Highest Hospital	Lowest Hospital	†Per Cent of Variation
Full Day.....	46.0%	26.0%	77
7 a. m.—3 p. m.....	43.0%	26.0%	65
3 p. m.—11 p. m.....	49.0%	27.6%	77
11 p. m.—7 a. m.....	71.7%	19.4%	269

†Lower figures used as base for computation of per cent variation.

Exhibit 1 describes those characteristics of the participating hospitals which could not be coerced into mathematical formulas. For example, the size of the school of nursing in proportion to the census, the existence of a central supply and postoperative recovery rooms, the service of food by dietary personnel rather than nursing personnel are factors which the reader may take into consideration while reviewing this study.

Exhibit 2 presents the hours of care per patient separated by shifts with high and low coverage contrasted with averages for the subject week.

Exhibits 3, 4 and 5 utilize the same structural pattern of Exhibit 2 to illustrate the percentage of care provided by graduate nurses, student nurses and auxiliary personnel respectively.

All hospitals in the study with one exception exceed the 3.5 hours of care formula. Hospital "F", the one exception, has a central sterile supply room and a postoperative recovery room, and the dietary staff assists the nurses by distributing food to the bedside of the patient. The average hours of care per day indicate considerable discrepancy between hospitals from a low average of 3.16 hours of care per day to a high of 4.97.

The distribution of hours of care by shifts also presents wide differences, particularly in the evening and night shifts. Note these weekly averages:

Shift	Highest Hospital	Lowest Hospital	*Per Cent of Variation
7 a. m.—3 p. m.....	2.64 hours	1.88 hours	40
3 p. m.—11 p. m.....	1.27 hours	0.70 hours	81
11 p. m.—7 a. m.....	1.02 hours	0.49 hours	08

*Lower figures used as base for computation of per cent variations.

It is revealing to discover the variation between hospitals in the way patient areas are staffed by graduate nurses, student nurses and auxiliary staff members. Note the accompanying comparisons. Hospital "I" is omitted from this table because it is in a unique situation which will be discussed later.

These statistics show clearly that only about half of the hours of nursing care are provided by graduate nurses. If this is generally true in other hospitals, perhaps patients are not receiving enough care even when the 3.5 formula is used and enforced. The 3.5 formula used to mean that graduate nurses provided three and one-half hours of nursing care per patient each day, but if 50 per cent or more of this care is now actually provided by non-professional people, the formula is certainly not adequate. Should we not raise the formula to 4.5 or 5 hours of patient care per day and determine what percentage of this care can safely be provided by auxiliary nonprofessional personnel and students?

It should be noted that the figures indicating the percentage of care by student nurses are significantly affected by the size of the school in relation to the patient census. Thus, Hospital "E" with a school enrollment of 65 and a medical-surgical census of 76 is in a much better position to provide a large proportion of patient

care by students than is Hospital "B," whose school is large, 85 students, but whose comparable census is 222.

We expected the location would have a marked effect upon the problems of staffing a hospital with nursing personnel. We were surprised to discover that, with the exception of Hospital "I," location appears to have little bearing on this situation. Similarly, an examination of the tables, hospital by hospital, discloses large disparities between institutions in the same area whereas in other instances there are closer similarities between institutions of diverse communities. "Home team" policies and practices hold greater influences over circumstances than uncontrollable environmental conditions.

The unique character of Hospital "I" deserves a word of explanation; indeed it may have few parallels in

the nation. It is situated in an enviable residential community equidistant from two metropolitan areas. There is considerable wealth and negligible indigency in the township. Consequently, the residents are able to pay for what they want in the way of hospital care.

An alert hospital administration is fully aware of this fact and provides accordingly. Because the community is a desirable place to live in, the problem of attracting competent persons to work in the hospital is less formidable than it is in other areas represented in the study. Consequently, we largely excluded the comparisons of this institution which can provide an average of 4.78 hours of nursing care, 84.9 per cent of which is performed by registered nurses!

The lowest hours of care were reported by most institutions for week-

end coverage, but we discovered that the percentage of care by graduate and student nurses held up better on week ends than did that performed by auxiliary staff people. Hospital "C," which had a much less significant spread between the highest and lowest days in the hours of care per patient, reported an interesting policy designed to cut down week-end census. The operating room schedule is rigidly held to a minimum on Saturday. Consequently, while fewer employees are available for week-end care, there are also fewer patients, which in turn helps to sustain a greater uniformity in the hours of care per patient at this hospital.

We believe that this detailed analysis of hours of nursing care in nine perfectly typical hospitals reveals something about this subject that is pertinent to all other institutions.

A formulary would help in **PURCHASING DRUGS**

A MODERN HOSPITAL ROUND TABLE



MR. JONES: With shortages of all kinds impending, it's time for critical examination of general practices in hospitals involving purchasing, store-keeping, stock issuance, inventory control and every other factor of the whole problem of operating supplies in hospitals. We have here the purchasing agent from a big hospital and the administrator of a big hospital. We all know that the general problem of purchasing in a small hospital is quite different from that of a big one. I suppose in the small hospital the administrator does a lot of the purchasing himself. Is that right?

MR. RODDE: I do all the purchasing in the hospital with the exception of pharmaceuticals.

MR. JONES: Who does your pharmaceutical purchasing?

MR. RODDE: At the present time the housekeeper, with the assistance of the director of nursing, she does all the purchasing of pharmaceuticals.

MR. JONES: Mrs. Mohr, you are purchasing agent in a big hospital.

PERIODICALLY, The MODERN HOSPITAL invites several administrators to sit down in our editorial office and discuss their problems. A recording of the conversation is made and the transcript is published here—after editing to eliminate repetition. Hospitals of all sizes and types are represented in these discussions, but the problems selected are those that seem to occur in all kinds of hospitals.

This month, the round table takes up the subject of drug purchasing and inventory control—vital hospital procedures in these days of rapidly emerging new "wonder drugs." Taking part in the discussion are Richard Vanderwarker, administrator of Passavant Memorial Hospital, Chicago (260 beds); Herbert R. Rodde of Highland Park Hospital, Highland Park, Ill. (85 beds), and Mrs. Orpha Daly Mohr, purchasing agent at Wesley Memorial Hospital, Chicago (616 beds). Everett W. Jones, technical adviser to The MODERN HOSPITAL, is moderator.—ED.

How do you handle pharmaceutical purchases in your place?

MRS. MOHR: The pharmacists make out the purchase requisitions, which come to me, generally defining who the supplier shall be, because our doctors order by trade names rather than drug names, as a rule.

MR. JONES: Actually, however, the signing and issuance of the purchase order are done in your central purchasing office?

MRS. MOHR: All the ordering is done in my office.

MR. JONES: What happens at Passavant?

MR. VANDERWARKER: The pharmacist orders his own pharmaceutical products.

MR. JONES: He actually issues his own purchase orders?

MR. VANDERWARKER: No. He sends orders to our purchasing agent, who in turn sends out the purchase order.

MR. JONES: In effect, then, you do about the same as they do at Wesley. Your pharmacist issues an order, which clears through the purchasing department as a matter of record and centralization. Is that right?

MR. VANDERWARKER: That's correct.

MR. JONES: I hear this business of who shall buy drugs argued pro and con all over the country, and I suppose the problem is quite different in a smaller hospital. However, I think it's rather unusual that the housekeeper should have anything to do with the purchasing of drugs. How do you account for that?

MR. RODDE: Actually, the housekeeper only reorders standard items of stock. On anything new, the director of nurses or I will instruct the housekeeper to go ahead and put in a supply. The variable items, such as trade names that we don't carry or things that must be compounded in the pharmacy, are ordered direct from the local pharmacists in town. Those do not go into the supply room. They go directly to the floor, to the patient. It's the standard supply of drugs that do not deteriorate that we stock in the supply room, and the housekeeper has charge of that supply.

MR. JONES: Do any of you have in your hospitals a pharmacy or drug committee through which you attempt to reduce the number of drug items you have to buy and carry in stock?

MR. RODDE: They created such a committee at Highland Park two years ago. The committee did go through the stock and limit the stock supply. This committee has not met or reviewed the supply set-up as we now have it.

MR. JONES: Have you done any standardization work at Passavant?

MR. VANDERWARKER: Frankly, we haven't. However, I would like very much to do it, because I think our inventory is excessive and we have a good many items that are duplicated.

MR. RODDE: You say that your inventory is excessive. Do you have any certain amount per day or per capita that you base that inventory on?

MR. VANDERWARKER: I can't answer that offhand. I can remember, however, in Hans Hansen's lectures at Northwestern University on pharmacy operation that there was a suggested amount. I'm sure our inventory is above average for the reason that we order and stock anything the doctors wish and, of course, we know that



Mr. Rodde



Mrs. Mohr



Mr. Jones



Mr. Vanderwarker

pharmaceutical salesmen have a good deal of effect on what the doctor orders.

MR. RODDE: It seems to me that Hansen did say about \$25 to \$30 per bed should be the drug inventory. I was just wondering what your inventory might be in a larger hospital.

MR. VANDERWARKER: I remember that our inventory was above the average figure given. Of course, a large part of our drug inventory in dollars today is in some of the very expensive drugs, such as ACTH and Cortisone, and that has thrown the ratios that were discussed three or four years ago out of line.

MR. JONES: I don't think there's any doubt about that. The average value of inventory per bed for pharmaceuticals today is probably double or more what it would have been four or five years ago, because of these drugs that you mentioned.

MRS. MOHR: I wouldn't be able to say the exact value of our drug inventory, but I do know we have a great deal of duplication because the doctors often demand a particular brand.

MR. JONES: If we could get hospital staffs everywhere to do as they have done in some hospitals and set up a real formulary committee and then establish a simplified standardized hospital formulary, everybody could cut down a lot on drug inventory. I recall that the University of Syracuse Hospital at Syracuse, N.Y., cut down from something like 3100 items in the pharmacy storeroom to about 800. As an example, they used to have 40 or 50 kinds of barbiturates under different trade names, and they ended up with just three kinds.

MR. VANDERWARKER: Certainly that's advisable, because a lot of money can be tied up in drug inventories. But it seems to me the only way to do it is through a formulary committee of the staff. You can't put the responsibility on a pharmacist without causing trouble with the staff, and the administration can't do it by dictating. What happened to the pharmacy committee of your staff at Highland Park?

MR. RODDE: The committee worked out a program for us, indicating trade names and amounts. Since that time, of course, many new items have appeared on the market, most of them extremely expensive, thereby increasing the inventory. The committee has not met since its final work two years ago, but it hopes and plans to have another meeting soon.

MR. JONES: Experience shows that if you don't review these items at least every four months, you'll find obsolete drugs on your shelf. If you're going to have a pharmacy committee at all, it's important that it should meet at least four times a year to review everything in the drug room and be sure the list is up to date. In some hospitals, those committees meet once a month, with the pharmacist and the administrator sitting in. The administrator is interested in the economics of the pharmacy because he spends a lot of money there.

MRS. MOHR: That sounds ideal, but doctors are very busy and to get them to spend that time is a difficult task! However, it would save a great deal of money in reduced space and cost if that could be done.

MR. JONES: We certainly call on doctors for things, but there's no use trying to form a pharmaceutical committee or standardization program if you don't have the staff in on it. I suspect more staffs would take part if we presented data to show them what the pharmacy is costing us and how much we might save if they helped us.

MR. RODDE: That sounds reasonable and feasible to me. But as Mrs. Mohr mentioned, it is difficult to get these men to meet and spend a few hours each month or quarterly to make decisions and help the administration reduce its costs.

MR. JONES: It's a much simpler task in a university teaching hospital, where you have a professor of pharmacology to sit in on the meetings. I've heard some hospital administrators say, "Why should we care about cutting down inventory or economizing?

We pass all these charges on to the patient anyway, and our pharmacy is a big profit maker." Is that a reasonable attitude?

MR. VANDERWARKER: Our main objective is good patient care. One factor in good patient care is giving service efficiently at the lowest possible cost. The pharmacy can help reduce cost by keeping a smaller inventory and thus the amount of money that is tied up. Furthermore, a smaller inventory will cut waste. People are more wasteful when there is a large supply and less control.

MRS. MOHR: I agree. However, when you have salesmen from the principal pharmaceutical companies out detailing the doctor, he naturally wants to try out the new drugs and see if he's able to get greater success than he has with the one he has been using previously. Your pharmaceutical committee would have to be very active to overcome this, I believe.

MR. JONES: Are the doctors in the smaller hospital constantly wanting to try the new things that come along?

MR. RODDE: Not too much. For example, when ACTH came on the market we had requests, and I presented the requests to the chiefs of services. They thought it best that inasmuch as this was a new item, we should have a committee to control its use within the hospital. That was put into effect until the men felt they knew enough about that particular drug. As soon as the men feel that a drug is valuable and it does what the literature says it will do, and that each man on the staff is aware of its dangers and its potency, then this committee steps aside and we reduce the barriers.

MR. JONES: Sometimes you hear people say, "Blue Cross will pay for the drug, and what's the use of worrying about how much it costs as long as it's going to be paid for anyway?" Isn't there some danger of swamping Blue Cross, if that attitude is too prevalent?

MR. VANDERWARKER: Many Blue Cross plans have difficulty in keeping their income balanced with their expenses, and the day has passed when we can say, "Let Blue Cross stand the expense," because it's liable to go under, and the hospitals would suffer severely.

MR. RODDE: The recent change in Blue Cross here eliminating x-ray payments proves that Blue Cross was being exploited, not only by patients but

**Readers are invited to
write to the editors
suggesting topics for
discussion at the admin-
istrators round table**

by physicians and hospitals. When these new drugs first arrive on the market, they are extremely expensive, and I think Blue Cross is perfectly right in limiting payments or issuing bulletins to the effect that this particular drug is not covered by Blue Cross. When the drug price is reduced because of volume production, that is the time that Blue Cross should consider adding payment for that drug.

MR. JONES: I like to remember Dr. Paul Hawley's remark, "Blue Cross protects the hospital and the patient, but who protects Blue Cross?" Certainly an intelligent job of purchasing in an effort to reduce inventory and cut unnecessary expense is part of the job of reducing cost so that Blue Cross can pay the bill, it would seem to me.

MRS. MOHR: In a teaching hospital such as ours, we have another problem. The residents or the interns may want to try out a new drug in order to learn. The chief of staff may agree to watch the drug and perhaps do actual research on it. However, the hospital and the patient are still paying the bill. Of course, if you just buy enough for a research project, that's one thing, but if you jump right in and put a big stock in before they know what the results are, that's something else again! It seems to me that should be watched carefully. When you take a new drug on, you should buy only research amounts and not stock way ahead until you know you want to keep using it.

MR. JONES: I've seen one hospital control that by making an application to the pharmacy committee necessary before a new drug could be put on the list, even for experimental purposes. The pharmacy committee would evaluate the literature and compare that drug with others already in stock. They might find that they already had the same thing in stock under another name. This procedure put a brake on wild experimentation with new drugs.

MRS. MOHR: Sounds wonderful—but you must have an active pharmacy committee!

MR. VANDERWARKER: If you did make a little effort to activate a pharmacy committee, wouldn't a lot of the physicians welcome it? I suspect that when they are pressured by detail men they would be glad to have some clearing house—some one who can tell them whether or not a drug had any particular property that didn't exist in another drug already being manufactured.

MR. JONES: Of course some people would say that's a fine way to stifle progress—to make an application to a formal committee necessary before you could put a new drug in. But actually where that's been tried it didn't seem to stifle progress or cause trouble. The doctors liked it, but it's still a tough job to get a pharmacy committee that is active enough and will meet regularly enough to do these things.

MR. RODDE: I don't think that the staff would be stifled, because most of these drugs are preannounced somewhat in the medical literature, so that the committee could start functioning and by the time a particular drug was released on the market, the staff would already have its recommendations from the committee and would know exactly which way to go.

MR. JONES: This all points to an interesting fact in purchasing: If you do not have a staff of doctors whom you can interest in your hospital problems and get them to cooperate and help you, you are severely handicapped in the purchasing function in many departments.

MR. VANDERWARKER: That is the biggest problem in hospital administration—including purchasing and all other phases of it. The hospital administrator cannot do an efficient job without the cooperation of the staff men, because they are in a position to influence many decisions. Cooperation has to be generated within the hospital. It is the administrator's job to educate staff members, tell them what's going on, bring them into the picture, make them partners in the venture—so they will accept some of the responsibility for control of expenditures. If we make an effort to do that, their interest can be generated and they can be of considerable help.

MR. RODDE: After this discussion it would behoove all of us to return to our hospitals and start working with the staff to start a formulary committee and get things going in the right direction.

The Evidence Is in Favor of DOCTORS' OFFICES in the Hospital

MEDICAL office buildings have existed in different parts of the country for some time, but it was not until recent years that they became associated with hospitals. For example, doctors in Washington, D.C., had the foresight to recognize the value of such an arrangement when, in 1939, a corporation was formed and Doctors' Hospital was constructed between the Columbia and Washington medical buildings, joining the three buildings. The doctors housed in these two medical buildings constituted the majority of Doctors' Hospital medical staff.

CLASSIFICATION OF OFFICES

The variations of office arrangements for doctors in hospitals can be classified into three categories: (1) group clinics; (2) offices within the hospital, and (3) offices adjoining or near the hospital.

Group clinics are generally well recognized as there are approximately 400 in the United States. Of this number, about one-fifth are in or closely integrated with hospitals. This development is having its greatest growth in the Far West and South.

Offices within the hospitals received their impetus in the 1930's, and this trend had its greatest advancement during this decade. According to record, Pennsylvania Hospital in Philadelphia converted two unused solariums into doctors' offices in 1936. Shadyside Hospital in Pittsburgh has had offices for doctors in the hospital since 1938. In 1939, Barnes Hospital in St. Louis provided office space for the same purpose. Another hospital that utilized an area in the hospital for doctors' offices during this decade is Western Pennsylvania Hospital, also in Pittsburgh.

This article is based on a dissertation submitted in partial fulfillment of the requirement for the degree of Master of Hospital Administration in the Graduate College of Washington University, St. Louis, June 1950.

LOUIS C. BROWN

Administrator
Hamilton County Public Hospital
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Although much has been said and many recommendations have been made for this practice of having the doctor's office within the hospital, little has been done in this regard since 1940.

By 1940, hospitals were regaining their stability economically, and the practice of transforming unused space into doctors' offices had subsided. In place of this arrangement, a new development of medical buildings with offices for doctors integrated with the hospital came into being.

Still recognizing the value of having doctors closely associated with the hospital, Pennsylvania Hospital, Philadelphia, further developed this trend by acquiring a building in juxtaposition to the hospital, providing office space for 37 doctors. In 1948, Bronson Methodist Hospital, Kalamazoo, Mich., drew up plans for a professional building to provide offices for the staff members. Probably the largest single unit that has become a reality in recent years is the Hartford Hospital Medical Building, Hartford, Conn., which accommodates a total of 102 doctors. This building, which joins the hospital, was completed in 1948. Memorial Hospital of Sandusky County, Fremont, Ohio, recognizing the lack of available office space in the city for the doctors, planned and built a medical building which was completed in 1950.

Other new medical office buildings that have been built or sponsored by hospitals are in Memphis, Tenn.; Little Rock, Ark., and Hanover, N.H.

HOSPITAL AS HEALTH CENTER

The people of the United States are demanding that the hospitals of this country progressively broaden the scope of their operations to offer bet-

ter medical care. This will include not only the provision of adequate bed care for the sick, but also the expansion of many hospitals into true medical centers. These new medical centers must provide a complete line of modern diagnostic and treatment equipment, sufficient capacity for those requiring bed care, and adequate facilities to handle ambulant patients of all classes.

In the literature relating to medical care today, we find increasing support for the centralization of health facilities in hospitals. Broadly stated, the future objective of the hospitals in the United States is to make available to every individual the preventive and curative benefits of modern medical science, as well as the important, and relatively new, field of restorative medicine.

Care of the ambulatory patient in the outpatient department, in group clinics or in offices in hospitals, using centralized facilities, should be expanded as a means of preventing hospitalization and providing additional service to the general public. This implies service to patients both before and after their stay in the hospital. Such services include advice, supervision, assistance and direction for convalescents and the chronically ill who do not need institutional care.

The follow-up services are valuable to both patient and physician in determining the effectiveness of the therapy provided during hospitalization and convalescence. Clinic service provides one of the best means for hospital participation in preventive medicine, particularly in the fields of mental illness, venereal diseases, tuberculosis and dental care.

The trend toward specialization in medicine creates an ever increasing need for consultation if the patient is to receive complete service. Compre-

*Hospital Association of Pennsylvania, Better Hospital Care for the Ambulant Patient, 1946, pp. 146-147.



Kelly Photo

Medical Building at Hartford Hospital is the smaller of the gleaming new structures.

hensive diagnostic service can therefore be furnished most effectively in a hospital where the specialties are represented. The facilities available in the modern hospital lend themselves to this type of service and greatly enhance the hospital's opportunity to serve the community.

In caring for the ambulatory patient, emphasis has historically been concentrated on outpatient clinics for the indigent. People in the middle income and high income brackets must seek adequate medical care through decentralized referral. Hospitals should provide not only clinics for indigent outpatient care, but group clinics for the part-pay and full-pay patients as well. The known fact that the middle income group of people in this country cannot pay for adequate medical care is the crux of the health problem before Congress and the people at large today. Where group clinics can be established in or near hospitals, it is recommended that they be conducted as a part of the work of the outpatient clinic.

BENEFITS OF DOCTORS' OFFICES

Some hospitals are not in a position to provide offices for doctors because of certain limitations in their physical plant. These limitations may be the bed capacity of the hospital; the physical layout; the lack of immediate adjoining property, or the location of the hospital. Many hospitals are not faced with these restrictions and could follow this new trend to their advantage. Locating doctors' offices in the hospital will ensure certain benefits to the hospital, to the patient, to the doctors, and to the community.

TO THE HOSPITAL

1. Any unused space becomes a major concern of the hospitals which are facing rising deficits with little hope of any relief from existing source of income. Therefore, the added income realized from utilizing such space for doctors' offices is financially beneficial.

2. The increased use of the diagnostic and therapeutic facilities will result in financial gain to the hospital. This additional income is derived from the transfer of work to the hospital services, as well as from the increased use of such facilities by doctors in their practice.

3. The acute shortage of nurses and technicians has crippled hospital operations in many areas of this country. An indirect benefit that might be derived from the proposed office plan is the concentration of diagnostic and therapeutic work in the hospitals, resulting in the release of personnel now employed out in the community by doctors for employment in the hospital.

4. At the present time, few hospitals are experiencing any difficulty in holding a high census. However, in normal times, hospitals admittedly compete with one another for patients. A doctor, by locating his office in a hospital, will tend to direct all his patients to that hospital. Therefore, these offices, indirectly, ensure the hospital a certain group of patients on a noncompetitive basis.

TO THE PATIENT

1. Many patients, if they are to obtain good medical care, must be seen by more than one doctor. The atmosphere of doctors' offices in the hospital lends itself to consultation service. The availability of specialists and their utilization for consultations will tend to reduce possibilities of diagnostic error.

2. Hospitalized patients will be seen oftener by the doctor because the time previously spent going from the office to the hospital is now available for hospital rounds, and unfilled office hours can be spent seeing these hospitalized patients. Thus, placing doctors' offices in hospitals should mean better medical care for both the ambulatory and the hospitalized patient.

3. Doctors' offices in hospitals should tend to reduce the cost of medical care. The referral system is a basic concept of modern medicine. The referring physician, however, is continually faced with the problem of keeping medical charges within the limits of a patient's pocketbook. As referrals multiply, the patient begins to accumulate a large medical bill. This bill also includes a charge for the highly specialized equipment now owned and used by doctors. Neither the referral charge nor the equipment amortization charge need be as high as it is at the present time. As more referrals are made to a specialist, these charges per referral could be reduced. Also, if much of the duplication of equipment throughout the community were eliminated, the cost of the remaining equipment could be spread over more patients.

4. Finally, "one-stop" medical care is achieved. All the many elements comprising modern medical care will be found at one location. This includes the multiple diagnostic services as well as consultations between doctors. Locating these medical facilities together can mean saving valuable time and effort for the patient.

TO THE DOCTOR

1. Time and energy saved by the doctor is considerable. By having his office at the hospital all the doctor's activity is concentrated there, whereas, if his office is at a distance and an emergency arises with one of his patients at the hospital, valuable time will be spent in traveling from his office to the hospital.

At the new Hartford Hospital Medical Building, discussed previously, it is conservatively estimated that the 102 doctors save 12,000 hours per year.

Having offices in close proximity to the hospital patient is especially advantageous to the surgeon and the obstetrician. The obstetrician can continue his work at the office until he is notified by the delivery room that his patient is ready to deliver. If the call is a "false alarm," only a few minutes will elapse before he can be back at his office. The hospital's operating schedule and the doctor's office hours can, in many instances, be changed with mutual benefit. Afternoon operating schedules will, at times, go far toward relieving the severe morning congestion in the various operating rooms, while morning office hours will be more convenient to surgeons and their patients.

Many physicians these days must work longer hours than is desirable. Perhaps the time saved under this new plan would make it possible to carry their present patient load during a shorter, more nearly normal, working day.

The time saved can be devoted to patient care, and, in teaching institutions, spent on ward rounds, in teaching, in outpatient clinics, or in research.

2. If the hospital has a complete medical armamentarium, this will cancel the need for duplication in many instances. The physician whose pattern of practice does not involve the retailing of the services of others will welcome these hospital facilities because they relieve him of the financial risks of such multiple enterprises and permit him to devote more time to

the sick and injured. He will be more the physician, for which he is trained, than the businessman, for which he is not trained. The use of these hospital facilities could also go a long way toward minimizing the practice of rebates and the splitting of fees, which at times, and in some places, are practiced to the detriment of the profession as a whole. These may be provocative statements, but they represent problems that must be met.

3. Diagnostic and therapeutic units are readily available to the doctors, and consultations can be held easily. Diagnostic information may be obtained directly from the radiologist or the pathologist. There is an opportunity to judge at first hand, if desirable, the material and findings of these laboratories and to consult with the laboratory men. With the roentgenologist and his x-ray equipment accessible, on-the-spot review of x-ray films makes possible diagnosis and/or change in the course of treatment without delay. There is no need to wait for film to be developed, read and delivered.

4. In order for a hospital to retain its tax-free status, it cannot make a profit on rents. Therefore, the rents doctors pay in hospitals are likely to be much less than those paid by doctors to real estate dealers.

If the doctors' offices comprise a group clinic, there are additional benefits that can be derived by the doctors, as follows:

5. Freedom from the details of business administration, as this is taken care of usually by a clinic manager.

6. Working hours are regular with practice covered during time off duty.

7. Vacations are scheduled in advance so that time will be given for them. These can be taken without danger of losing patients or income. This is also true for medical meetings and postgraduate study.

8. Group practice results in an exceptionally fine type of medical care. Every participating physician must conform to the code of the entire group. Professional standards are maintained since each doctor is aware that his error or his slackening in acumen will be recognized readily by his colleagues. Quite naturally, this phenomenon leads each physician to maintain his reputation and to be highly regarded by his co-workers. The patient also benefits from the fact that doctors who have been remiss in their duties or whose attitude to-

ward patients has been poor are called to account.

9. For the young doctor this is an opportunity to start with little or no financial backing and yet earn a good income, keep busy from the beginning, and retain the skills acquired during training.

COMBINED BENEFITS

1. When doctors' offices are located in or near the hospital, the patient's entire medical record is available to the physician for office use. He may utilize it in diagnosis and add to it the findings of each visit. Not only does this assure the hospital of a more nearly complete medical record, but also the patient may be helped because it is complete.

2. Emergency care creates a definite problem for many hospitals. The hospital's responsibility for the patient must, in the true sense, parallel that of the doctor's. To have a doctor within quick call provides a form of security in the care of the patient that cannot be wholly estimated. This is especially true in hospitals that are not fortunate enough to have residents or interns.

3. The patient enjoys a sense of security when he enters the hospital as a patient if he has visited a doctor in his hospital office previous to admission. Fear is reduced by the constant assurance of his doctor's being near. The offensiveness of the hospital is also reduced by previous visits. By seeing patients on stretchers or in wheel chairs, one becomes accustomed to the hospital atmosphere. The advantages are both tangible and intangible. A visit by a patient under conditions not associated with overwhelming illness tends to dispel the old and frequently still present antipathy to hospitals. Patients have an opportunity to see the hospital in a way that is uncolored by the distraction of a painful hospitalization or the grief attendant on the loss of someone dear to them. Finally, lessening a patient's fear constitutes a definite aid to recovery.

TO THE COMMUNITY

The benefits to be derived by the community from doctors' offices in the hospital are the same the hospital receives. These advantages can be covered in one statement, that is, the people of the community will receive more and better medical care. As the community becomes more health con-

scious, it can take advantage of the preventive aspects of medicine before curative therapy is necessary. The entire community will benefit from the hospital in its developing trend toward being a health center.

DISADVANTAGES OF THE PLAN

1. Appropriating funds to initiate such a venture is a difficult hurdle. This is the primary obstacle to overcome after the need is assured.

2. Size of the hospital or population of the city in which the hospital is located may not lend itself to the provision of doctors' offices. It might also be that the doctors are on more than one hospital staff.

3. Location of the hospital is a drawback in certain instances. If the hospital is in a slum or industrial area, even though it may be reputable, people tend to identify it with the area. Also, unless the hospital can be reached easily by public transportation many patients may prefer to go to a neighborhood doctor. This is found to

be a hindrance in locating doctors' offices in hospitals.

4. "We are accused of being in the real estate business," stated one hospital executive. Although hospitals are, to some extent, in the real estate business, they cannot be identified as such and still retain their tax-free status.

5. One administrator gave his chief objection as "patient nuisance." "The doctors' patients mill around the hospital while waiting for appointments, and many of them insist on visiting hospital patients."

6. Another administrator listed the dangers of doctors living too close to the hospital as: (a) hospital gossip—tendency at times to "get in the hair" of administration; (b) doctors watch the admitting office for possible vacant beds, and (c) during idle hours there is a tendency to loaf in various hospital departments.

7. In several instances the medical staffs fear there is prejudice in the allocation of available offices and then

jealousies arise. It is also feared, in some instances, that those doctors with offices in the hospital will have preference in the assignment of available beds for their patients.

8. In teaching hospitals where faculty members are permitted to have a private practice, a complaint is made that in some instances a faculty member or department head accelerates his private practice, at the expense of charity patients, until the maximum amount he is allowed to earn is reached. Then, the department reduces its functioning a great deal for the remainder of the fiscal year.

9. Doctors in private practice away from the hospital proper complain that the scheme gives staff members an unfair economic advantage through the sharing of facilities; in other words, unfair competition.

Some of these disadvantages found by hospital administrators and physicians, while justified, are overshadowed by the advantages that can come from providing doctors' offices in hospitals.

PROBLEM: Building a new psychiatric department SOLUTION: A two-ward, 16 patient building

EARLY in 1948 it was apparent that the psychopathic facilities at Portland City Hospital, Portland, Me., were inadequate to care for demands being made on the hospital. After the completion of the budget study for 1949, plans began to take shape. Wadsworth, Boston & Tuttle were engaged as architects.

The resulting structure consists of two eight-bed wards, two restrooms or sun rooms, diet kitchen, utility room,

treatment room and a reception room. A vestibule leads to the outside entrance to a newly constructed ramp where the ambulance may drive up to the entrance of the hospital. The building is so situated that the brilliant sunlight and daylight will give added pleasure to patients.

The total cost of construction of the annex and a sprinkler system throughout the entire hospital was \$95,630.07. Of particular interest is

the fact that the actual construction cost of the new addition is less than \$4000 a bed, compared to the usual present-day cost of hospital construction of more than \$10,000 a bed.

Exterior walls are of cinder block faced with brick, and walls are waterproofed with a membrane system. Floor and roof construction are of reinforced concrete slabs supported on steel joists. Finished first floor is of asphalt tile.

View of eight-bed ward (left) and exterior (right) of new psychiatric building which is an annex to the Portland City Hospital, Portland, Me.



Small Hospital Forum

Give Them a Chance to Complain —

—and the chances are they won't

LEONARD W. HAMBLIN

Administrator
Deaconess Hospital
Freeport, Ill.

AT THE Deaconess Hospital in Freeport, Ill., we think we have solved one phase of the public relations problem. We have found an effective, economical way to obtain constructive criticism of our hospital. Administrators and hospital board members know that it is difficult to improve their service if they don't know where the weak spots are. Prior to our present system we used a card which merely asked a patient to make suggestions for improved service. These were supposed to be given to each patient by the supervisor or head nurse just prior to the patient's discharge. This plan failed for the following reasons:

1. Supervisors and head nurses did not take the responsibility of seeing that each patient received a card.

2. Nurses and other employees on the floor were irritated with the cards, feeling that criticism expressed on them would be directed against themselves.

3. Because the difficult patient would be harsh in his criticism, he would seldom be given a card.

4. A card was usually given to a patient near discharge time when he did not care to give time to filling it out; consequently, it was usually lost or misplaced.

It was of paramount importance that we learn what criticisms there might be of our hospital and that we take bold steps to correct situations which prompted these criticisms. A little over a year ago we successfully completed a building fund campaign in which we raised \$385,000, the largest sum our community had ever been asked to do-

Dear Patient:

Your hospital is constantly seeking to determine which of its services are adequate and which could be improved. As a resident of the community you are interested in the services rendered by Deaconess Hospital. Therefore, will you please answer the following questions?

	Yes	No
1. Was the schedule (treatment, baths etc.) of the hospital so arranged that you could get enough rest?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Did you receive the kind of food you like (if your diet permitted)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Were the nurses prompt in doing things for you (answering your light etc.)?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Was the service of your nurse (white cap and white uniform) what you expected?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Your nurses aide (no cap — both colored and white uniform)?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Did you receive a friendly and adequate introduction to the hospital from the admitting officer (person who asked birthplace, occupation, previous admission, etc.)?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Were the employees who cleaned the furniture and floors in your room tactful (not talking too much)?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Did you receive courteous, skillful treatment from the laboratory technician (she drew blood for tests)?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. Was your food hot by the time it reached you?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Was your coffee good?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Were the employees in the business office tactful, courteous and helpful at time of discharge?	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Suggestions or criticisms

See note

Thank you
Deaconess Hospital

Name Mrs. Walter King Room No. 225

nate to any single cause. We needed to keep the good will of the people who had donated so freely to this campaign.

It took the combined efforts of the public relations committee of our board of trustees, a printer, and the administrator to arrive at our present system. A meeting of the captains and majors who had worked on the building fund campaign was held for the purpose of learning what criticisms of our hospital services they had heard during the course of the campaign. This proved to be a good way to find out "how others see us," and in what way the hospital was unsatisfactory in the eyes of the community.

The card we now use is reproduced on the opposite page. Its first draft was on a sheet of paper many times the size of its final postcard form, and included questions which we thought provocative. We then edited and polished until we arrived at the questions which seemed most important and which would meet the limitations of a postcard.

Our next problem was to determine how and when to present a card to a patient. We felt that it would get the best results if these cards reached the patients after they had returned home. At Deaconess Hospital a full bill is mailed to all patients after discharge. We decided to enclose one of the new cards with each bill mailed out. The cards were the business reply type which require no postage of the sender. Those returned cost us 2c in postage plus the cost of the card and we think it is a small amount to pay for the good they do both the patient and the hospital. The patient feels relieved if he had a complaint and pleased to help us with constructive criticism. The hospital finds out which of its services need improvement. When we receive complaints of a particularly serious nature we telephone, write or visit the patient and in most instances we find that we gain good will in doing so.

About 3000 cards have been sent out under this new system and approximately one-third have been returned. The following tabulation is of 300 cards selected at random from among those returned.

Questions	Yes	No	Not Marked
#1	298	2	
#2	293	7	
#3	297	3	
#4	296	2	2
#5	298	2	
#6	296	1	3
#7	300		
#8	297	2	1
#9	288	12	
#10	299	1	

Judging from one large group of replies one might think that all you have to do to run a hospital successfully is to serve good coffee. Question 9—Was your coffee good?—drew the largest number of adverse answers. Strangely enough, the comments ranged all the way from "too strong," to "too weak." Some patients said it was cold by the time they received it. We can't do much about the complaints about strength since we are now satisfying the taste of the majority. By placing coffee in vacuum containers for transportation to the various floors the "cold" complaint has been eliminated.

Question 2—Did you receive the kind of food you like?—drew the second largest number of critical replies. Since questions 2 and 9 both concern diet it seems clear that patient satisfaction

will exist in direct ratio to the extent to which the diet pleases.

Criticism on the other questions were few and as vagarious as the human beings who made them. One complained that not enough spiritual ministrations were provided. Several expressed a desire to receive a final statement at the time of discharge. Others felt dissatisfied with back rubs, or the equipment available for passing the time, or disturbances caused by visitors, and the loud voices of some of the nurses and other employees.

In the replies received satisfaction with the services covered in most questions asked ran high. This is naturally gratifying. However, inasmuch as we hope to be able to maintain satisfaction in the phases of our services covered under these questions we plan, when we print more cards, to use a different set of questions. In this way we hope to learn if there are other of our services which are not satisfactory. You cannot correct mistakes in public relations if you don't recognize them.

Administrators and hospital boards will find these cards highly effective instruments in creating good public relations. If you can relieve your patient of his complaints you are also making a favorable contact with his family and visitors. It doesn't take long in this way to reach a large section of the community at the one time when the people reached are particularly receptive to your public relations efforts.

Long Live the Syphilologist

The lively eulogy "The Dying Syphilologist" by Charles C. Dennie, M.D., in the November 1950 *Archives of Dermatology and Syphilology* certainly belies its title.

The author strides away unscathed leaving several score of wounded internists, medical educators, roentgenologists, syphilo-statisticians and penicillin injectors scattered about the arena. He even takes on the army and navy, claiming they are "seeking to eliminate the marine and the dermatologist, the two most efficient members in their respective fields."

The blithe assumption that penicillin will cure all syphilis is a foolish and dangerous one, the author maintains. The 20 to 30 per cent of seropositives who are not helped by the wonder drug are severely handicapped by the lack of interest in the now unfashionable heavy metals. The mod-

ern conveyor belt syphilis clinic, with its technicians and statistics-mad chief, depends entirely too much on serology as a positive indication of successful treatment. The clinical manifestations of the disease and the accompanying pathology are brushed aside as unimportant.

The author does spare his own fellow dermatologists. He recommends excellent groundwork in internal medicine before specialization, claiming most skin diseases are but reflections of internal pathology. The mere observation of a small area of skin is not enough—a complete physical examination should be given to all patients.

This article and recent events seem to indicate that the marines and their allies are still far from extinction. —JOHN D. THOMPSON, *Montefiore Hospital, New York City.*

◀ "Keep the old men who call hogs all night in soundproof rooms," one former patient complained. Most of the criticism received by Deaconess Hospital has had to do with coffee or other dietary items.

TRUDEAU AND KOCH

made hospital history

By OTHO F. BALL, M.D.

President, The Modern Hospital Publishing Company, Inc.

THE sun was glaring down on the street noisy with its rush of traffic, but the stricken young doctor saw only a dull, darkened world around him. Only 25 years old, with rosy dreams of professional achievement ahead, and in six months he would be dead! He was stunned by this sentence of death just received from the noted diagnostician, Dr. Janeway, whose examination had revealed lungs badly involved with tuberculosis. He remembered those terrible months when, penned in a little tightly closed room, he had nursed his beloved brother and watched him die in agony of this terrible disease. He thought of his young wife happy in their new home with their baby girl and he dreaded what he must tell her. The practice he had just entered with an established physician—the bright future—now nothing but suffering and death, for at that time tuberculosis spelled early death.

BREAKING THE BAD NEWS

Edward Livingston Trudeau lived many years after that fateful day, finding a way to prolong his own life and to save thousands of others. Ever afterward memories of his bitter anguish that morning in his young manhood helped him to break similar news to other tuberculous persons with a gentleness and understanding that led them to accept the inevitable if the disease was far advanced, or to hope if any hope could be held out. In the little community that grew up around Trudeau he became, like Osler, a Beloved Physician, merciful, kind and self-sacrificing.

On his mother's side Trudeau (1848-1915) came from a long line of physicians of New Orleans. His father, James Trudeau, whom he never knew, for his parents separated when he was born, too was a physician. He was also an artist, an adventurer, a lover of the outdoors, a friend of Audubon, accompanying him on his trips, and for two years companion of the Osage Indians, who knew the story of the rescue of their former chief by his grandfather Zenon Tru-

deau, governor of Les Illinois. The Trudeau family moved to Paris in 1851 but returned at the end of the Civil War and settled in New York. After the shock of his brother's death, Trudeau wandered with his rich and idle companions, now and then trying out some job or profession and giving each one up, until he fell in love with a clergyman's daughter and decided to be worthy of her and establish a home. He turned to the profession of his forebears and in 1899 was graduated from the College of Physicians and Surgeons.

Trying first to follow his physician's advice to go South and go horseback riding for exercise, which was prescribed as a possible cure at that time for tuberculosis, Trudeau grew worse. Taking his family, to which had been added a son, to the old parsonage, Trudeau against the pleas of his fearful friends took himself to the wilderness where he had spent so many happy hours. It was a hard, pain-wracked trip to Paul Smith's inn in the Adirondacks, the last 42 miles over a rough corduroy road, with the sick man lying on balsam boughs in the bottom of the stage-wagon. Arriving at the inn, a friendly guide carried the wasted body up the stairs to bed.

Rest, fresh air, and good food, which later became his formula for treatment of tuberculosis, brought him renewed strength and he returned to New York City, only to have the fever return. Gathering together his little family, he took them up to the bitter cold of the Adirondacks, where, his friends believed, he would surely and

quickly die. There in the woods he began to improve. The guides took him fishing and hunting, which he loved, and without rising from his bed in the boar he was able to enjoy the sport. He was a man who easily won the affection of those around him and the guides adored him. As he grew better he tended their sick, human and animal, and took no pay.

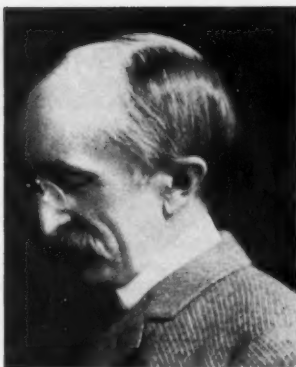
With his small inheritance he was able to establish a little home at Saranac Lake and gradually as his fever and cough left him, he cared for patients who sought his services. Summer visitors at Paul Smith's carried forth the story of his conquest of tuberculosis and gradually patients from near and far came to seek his help. There was no place for them to stay except at the inn and the small homes about. Reading of the sanatoriums of Bodington in England and Brehmer in Silesia, Trudeau began to dream of a sanatorium that would provide air, rest and food for those who suffered from his dreadful disease. He was particularly interested in the unfortunates who couldn't afford to pay for board and room in the healing wilderness.

FUNDS FOR HIS NOBLE DREAM

Then began his lifelong work of begging funds for this noble dream. He rarely convinced anyone that he could heal the tuberculous, but such was the magnetism of the man that the first trip out of the woods to New York brought \$3000 in cash and more in promises. Always afterward when he wanted a new cottage, improvements of water and sewage, additions to the



Robert Koch



Edward L. Trudeau

laboratory, there was a friend or a former patient or a relative of a patient who had been helped, who would come forth with the needed money.

All through those years, with money pouring in, Trudeau took nothing for himself. The charges were far less than the cost and each year there was a deficit which friends would meet. Trudeau himself managed to get along on his inheritance and the small income from his patients. His practice was necessarily limited by his continued ill health and long months of prostration when the old enemy flared up to torture him.

With no rival in the field, as one friend stated, had he chosen he might have commanded a large practice and enjoyed a great income. He said one time that he had never earned more than \$7000, and that for only two or three years. A fortune was his for the asking but all he desired was help for his growing sanatorium. When he was given a fine horse and wagon to replace aged Kitty, "the old plush horse," and his ancient buggy, he hesitated about accepting them, lest people might think the sanatorium no longer needed money.

From the first two-patient cottage, without water supply, with only bare furnishings, the sanatorium grew around a cluster of little cottages, the first institution devoted to the care of the tuberculous in the country, the forerunner of many such institutions which arose in the succeeding years all over the United States. It is too long a story to tell here, although in omitting the story of its development, one cannot tell the full story of Tru-

deau's life, for the sanatorium, its gradual building, its maintenance, and the care of its sick—that was Trudeau's life.

But even before Trudeau began to make his dream come true, scientific discoveries were being made known by Robert Koch that altered the whole picture of tuberculosis and the care of its victims.

BOY KOCH TAKES TO SCIENCE

Over in Germany, Robert Koch had startled the world with his discovery of the tubercle bacillus. Unlike Trudeau, Koch came from a very poor family. One of 11 boys, he shared their patched clothing and their scanty food. Very early he began to show an interest in natural science and with an old scratched pocket lens he sought to learn its mysteries. By the time Robert was graduated from the gymnasium, the family fortunes had become better and his father, recognizing the genius of his son, managed to send him to the University of Göttingen.

Graduating in 1866, Koch entered the medical school with the idea of becoming a ship's doctor and seeing the world. His father and the woman he was pledged to marry upset that hope and instead he explored the world of the unseen living organisms. He settled down as district physician and to these duties he added private practice which grew rapidly. On his twenty-eighth birthday the wife presented him with a microscope. Stirred by the discoveries of Pasteur and Lister, he plunged into the world of bacteriology. Since this is a story of Trudeau and his fight against tuberculosis, little

can be included of Koch's great discoveries except that of the tubercle bacillus and its effect on the work of the tuberculous physician fighting the disease in the bitter cold of the Adirondacks.

Koch's first great discovery, that of anthrax, brought him world recognition, for this disease was widespread among animals. In an effort to inoculate mice with the bacilli and thereby prepare a vaccine against the disease, he devised means of preparing slides for study and a method of culturing the bacilli that remains almost unchanged today and thus developed bacteriology as a science. Six years later he announced discovery of the tubercle bacillus. In a world where tuberculosis was King of Killers, this was joyful news and every facility was offered Koch to pursue further study of the disease. Honors poured upon him and in 1890 when he stated that he had prepared a tuberculin, specific against the disease, the great news spread around the world. From the destruction of his own and the disappointed world's great hope, Koch never quite recovered, but he threw himself with even greater vigor into new research against great epidemic diseases, a work that took him into many lands. Malaria, sleeping sickness, bubonic plague, leprosy, these were only a few diseases that he successfully studied. Five years before his death (in 1905), he received the Nobel prize, and countless well-deserved honors were bestowed by the grateful nations of the world.

TRUDEAU LEARNS OF KOCH

Up in the woods of the Adirondacks Trudeau read with enthusiastic interest abstracts of Koch's discovery of the tubercle bacillus and, recognizing the importance of this wonderful news, mourned because he could not read the whole article in its German text. Lea, a member of the noted publishing house, gave him as a Christmas present that year a handwritten translation of Koch's article, one of Trudeau's most valued treasures. He immediately wanted to repeat Koch's experiments, but first he must learn to prepare slides. In the College of Physicians and Surgeons he laboriously acquired the necessary laboratory technic. Hurrying back to Saranac Lake, he set up in his home a crude laboratory with the simple apparatus he could obtain or could make with the help of the village tinsmith.

(Continued on Page 132)

About People

Administrators



H. E. Bishop

Howard E. Bishop is retiring from active hospital work on July 1. Mr. Bishop, administrator of Robert Packer Hospital, Sayre, Pa., has spent 39

years with that institution. For all of those years he has been a member of the hospital's board of trustees as well as administrator. He expects to continue as a trustee. Mr. Bishop was a charter fellow and, in 1937, president of the American College of Hospital Administrators; a charter member, former president and for seven years executive secretary of the Hospital Association of Pennsylvania, and long has been active in A.H.A. committees and councils.

Dr. Clifton H. Smith, manager of the Veterans Administration Hospital at Atlanta, Ga., has been appointed manager of the V.A. hospital on Cold Spring Road, Indianapolis. **Dr. E. H. Hare**, former manager of the Cold Spring Road V.A. hospital, is now manager of the new V.A. hospital at the Indiana University Medical Center.

Ernest M. Sable has assumed his new position of assistant superintendent at Cedars of Lebanon Hospital, Los Angeles. Previous to this appointment he was the assistant director of Mount Zion Hospital, San Francisco. A graduate of the course in hospital administration at Yale University, he took his administrative residency with **Dr. Charles F. Wilinsky** at Beth Israel Hospital, Boston.

S. Chester Fazio, for many years administrator, St. John's Riverside Hospital, Yonkers, N.Y., has been appointed administrator, Hillcrest Hospital, Pittsfield, Mass. Mr. Fazio has written many articles on community hospital organization, some of which have appeared in this magazine. He is a life member of the American Hospital Association, an active member of the New York State Hospital Association, and past active member of the Pennsylvania Hospital Association.

Dr. Cleve C. Odom is the successor of **Dr. George Jackson** as state hospital superintendent in Arkansas. A veteran

of 30 years of army medical service, he directed some of the first and some of the largest psychiatric hospitals operated by the army during World War II. Following his retirement he became manager of the Veterans Administration Hospital at Augusta, Ga., and since October 1949 has been superintendent of South Carolina State Hospital and director of mental health for the state. **Dr. Jackson** has accepted a position as director of mental health in Texas. **Dr. Hayden H. Donahue**, assistant superintendent in Arkansas, has resigned his post to become **Dr. Jackson's** assistant in Texas, and **Dr. Oscar Kozberg**, acting superintendent in Arkansas, has announced his resignation because of poor health.

George R. Wren is the newly appointed administrator of Methodist Hospital, Gary, Ind. He is a graduate in hospital administration from the University of Chicago and served his residency at Methodist Hospital, Indianapolis.

Mrs. Lillian Swenson, for the last seven years head of the Eldora Memorial Hospital, Eldora, Iowa, has resigned from that post and has been chosen superintendent of the new Clarion Community Memorial Hospital, Clarion, Iowa. Previously, Mrs. Swenson was instructor in nursing arts at three hospitals in Illinois.



Harry N. Dorsey

Dorsey served as executive officer at the station hospital at Shaw Field, Sumter, S.C., and in various other hospital administrative capacities. Following his service in the army he was appointed an administrative assistant at the Johns Hopkins Hospital in Baltimore, serving there until September 1948 when he left to complete work on his B.S. degree in commerce at Loyola University, Chicago, before commencing studies at the University of Chicago last September.

Mrs. Mildred H. Mitchell has been named assistant superintendent of the University of Chicago Clinics in charge of Chicago Lying-in Hospital succeeding **Frank**



Mildred Mitchell

R. Shank, who resigned to accept the position of director of the Springfield Memorial Hospital, Springfield, Ill. Mrs. Mitchell has served as administrative assistant at the University of Chicago Clinics since 1945.

George Peck has been appointed assistant director, Newark Beth Israel Hospital, Newark, N. J. Mr. Peck was formerly administrator of Jewish Hospital, Philadelphia.

Paul F. Detrick has been appointed administrator of the Arkansas City Memorial Hospital, a 91 bed general hospital which opened recently in Arkansas City, Kan. Mr. Detrick, formerly administrative resident at Bethany Hospital, Kansas City, Kan., has completed the academic work for a degree of master of hospital administration at Northwestern University.

Nellie Mumford, R.N., has resigned her position as personnel director at the Rice-Stix factory at Lebanon, Mo., and has accepted the post of general superintendent of the Louise G. Wallace Memorial Hospital at Lebanon. Miss Mumford, a graduate of the nurses' training school at Burge Hospital, Springfield, Mo., took postgraduate work in the Gradwohl School of Laboratory and X-ray Technique, St. Louis. She spent four years at the Stouder Memorial Hospital, Troy, Ohio, as laboratory and x-ray technician, and in 1934 she became the first superintendent of the Louise G. Wallace Memorial Hospital, serving in that capacity for 12 years.

Clarence C. Gibson has resigned his position as manager of the Ector County Hospital at Odessa, Tex. He is the former manager of the El Paso City-County Hospital, El Paso, Tex., and of Regina General Hospital, Regina, Sask.

Mrs. Jesse McGrath, R.N., has succeeded **Rita Schabel, R.N.**, as superintendent (Continued on Page 158)



SIMPLIFY for SAFETY with CUTTER

specify the new
Saftifilter*
all-plastic blood infusion set

the set designed to
withstand positive pressure

get all these advantages of safety and improved technic in blood and plasma infusion:

Added Safety—3-stage filtration—coarse, medium and fine—removes clots and fibrin and provides even flow.

Breakage Resistant—All-plastic construction with sparkling-clear visibility.

Plastic Needle Adapter—Provides vein entry visibility—is linked with latex connector for additional medication injections.

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Ask your hospital supplier to demonstrate the time and trouble saving features of this new Cutter Saftifilter.

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Increase Safety
Simplify Technics
Cut Costs With

CUTTER Saftifilter
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designed and made by the producers of safe, sterile, pyrogen-free Cutter Saftiflask® Solutions

Cutter Laboratories • Berkeley, California

A BLUE CROSS-SECTION

of 10,000 patients gives new facts

ABRAHAM OSEROFF

Vice President, Hospital Service Association of Pittsburgh

WHAT do Blue Cross subscribers think of us today? Are we meeting their needs? Are we as important to them in these days of higher incomes as we were in times of depression?

Although our enrollment of more than 1,600,000 members—one out of three in Western Pennsylvania—and the sum of approximately \$15,000,000 paid to hospitals last year give a mass picture of successful service, we wanted to know the reactions and opinions of the individual subscriber. We decided to ask him a few direct questions through use of an extensive survey.

On Oct. 2, 1950, our first survey questionnaire was returned. Less than six months later we had heard from 10,000 hospitalized subscribers who told us what this Blue Cross plan—and the hospitals which sponsor it—mean to them. This large scale sampling of subscriber opinion has thrown new light on the service we provide, and may be of interest to other Blue Cross plans and hospitals nationally.

The answers from 10,000 voices of experience proved what many of us had previously assumed, and offered new facts which provide the basis for a better understanding of the relationships now existing between Blue Cross, the hospitals, and the subscribers.

FOUR PRINCIPAL FINDINGS

Results of the survey conducted by the Hospital Service Association of Pittsburgh show that:

1. More than 70 per cent of the subscribers would have been collection

department problems for the hospital had they not been Blue Cross members.

2. One out of every 10 subscribers would have been treated at home if his hospital bill had not been prepaid through Blue Cross.

3. More than 66 per cent of the Blue Cross members employing special nurses did so because Blue Cross had relieved them of other financial obligations.

4. Member hospitals are doing an excellent job in providing Blue Cross benefits as evidenced by the complete satisfaction expressed by 97 per cent of the subscribers covered in the survey. More than 98 per cent stated that they would recommend Blue Cross protection to their friends.

Although we may assume that the average subscriber now receives higher wages than he has at any time in the past, our survey proves that he is no better prepared to make cash payments for hospital services than in less "prosperous" times. When asked "Would it have been difficult or impossible to have paid your hospital bill without the Blue Cross benefits provided?" more than 7000 persons—7 out of 10—frankly answered "Yes!" The following comments are typical of many which were voluntarily added to the survey questionnaires: "We would have been over our heads in debt"; "I would be so far in debt to hospitals that it would take 10 years to pay off," and "I would have had to borrow money to pay the hospital bill."

In addition to the financial aid provided, the hospitals and Blue Cross

plans have preserved the dignity and self-respect of the hospital patient. He is proud that he has had the foresight to prepay his expenses, and, thanks to the member hospitals' acceptance of the Blue Cross identification card, he does not have to provide credit references. The ease with which Blue Cross members are admitted to hospitals has produced confidence in the hospitals and plans and a sense of appreciation that can never be adequately measured.

The survey gave concrete evidence that Blue Cross increases the utilization of hospital facilities. Of the 10,000 patients who answered the questionnaire, 1057 reported that they would not have gone to the hospital for treatment if they had not been Blue Cross members. This percentage was higher than expected and suggests that many Blue Cross admissions are primarily for the convenience of the doctor or his patient. In any event, it means additional income for hospitals and opportunity for broader service to the community.

It is also indicated that the use of private duty nurses in the hospital has been increased through the Blue Cross plan. Hospitalized subscribers were asked whether or not they had employed a special nurse. Those who had were then asked: "Was this additional service made possible by the fact that Blue Cross had relieved you of other financial obligations?" More than 66 per cent reported that they were able to do so because of Blue Cross benefits.

SATISFACTION IS GENERAL

The extent to which hospitals are creating good will for themselves and for Blue Cross is reflected in the opinions of the 9713 patients who acknowledged their complete satisfaction. It is confirmed in hundreds of subscribers' comments praising the plan and hospital separately for the services received, and jointly for the close association which enables such a program to operate for the individual and community welfare. This general expression of subscriber satisfaction should be reassuring to hospitals as well as to the plans. Certainly the progressive attitude of the Blue Cross plans throughout the country has been instrumental in the development of a highly effective system of prepaid hospitalization, but it is the hospitals themselves that remain the important point of contact between the patient and the Blue Cross benefits he receives.

RAPID DISAPPEARANCE OF DIARRHEIC STOOLS



*permitting
early re-alimentation and hydration
by the oral route¹*

Recent studies^{1,2} have demonstrated the unusually dependable value of Arobon in acute diarrheas of infants and children. Within a matter of one to two days, in the majority of patients the stools thicken and lessen in frequency. Thus early re-alimentation and hydration by the oral route and earlier resumption of normal feeding are possible.

Arobon, processed from carob flour, owes its pronounced anti-diarrheal activity primarily to its high content of lignin as well as pectin. Absorbing a considerable amount of water, it swells to a bland, smooth, bulky mass in the intestine, which eliminates offending bacteria and toxins with the stools, thus causing the diarrhea to subside quickly.

Arobon is indicated in all types of diarrhea in infants and children. It is palatable and readily tolerated. Arobon is ready for use by merely boiling it in water for ½ minute.

1. Smith, A. E., and Fischer, C. C.: The Use of Carob Flour in the Treatment of Diarrhea in Infants and Children, *J. Ped.* 35:422 (Oct.) 1949.
2. Kaliski, S. R., and Mitchell, D. D.: Treatment of Diarrhea with Carob Flour, *Texas State J. Med.* 46:675 (Sept.) 1950.

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**SPECIALLY PROCESSED CAROB FLOUR
HIGH IN PECTIN
AND LIGNIN**



A final statistical point proved by the survey is the advantage of offering subscribers the additional protection of Blue Shield immediately following their hospitalization. Of those who stated that they were not Blue Shield members, nearly 76 per cent requested further information on the medical-surgical plan. This interest is naturally related to their recent experience with health care needs and opens the door to increased group and nongroup enrollment.

In the over-all picture, the response to the survey was a wholehearted endorsement of the voluntary hospital system and the voluntary nonprofit hospitalization plans. Of the 10,000 persons included in the survey, 102 failed to state whether or not they were satisfied with the services received, and only 185 expressed dissatisfaction.

The most frequent objection came from subscribers who complained that they were placed in either ward or private rooms because semiprivate accommodations were not made available. Others reported charges erroneously entered on their hospital statements for services they did not receive. The exclusion of diagnostic x-rays also produced complaints, as did the arbitrary definition of certain procedures as "diagnostic" when the subscribers felt they were consistent with the diagnosis and treatment.

In some cases the survey confirmed our own decisions concerning desirable changes in plan benefits. For example, many subscribers suggested a greater allowance toward the use of better accommodations, and more nearly complete drug coverage. These improvements were already under consideration and, effective with admissions on or after Feb. 1, 1951, the Hospital Service Association of Pittsburgh increased the private room allowance for semiprivate subscribers from \$5 per day to \$8 per day. Members holding ward contracts were allowed \$5 per day toward the cost of private or semiprivate accommodations instead of the previous \$3.50 per day. At the same time, drugs listed in "New and Non-Official Remedies" were added to those listed in the U.S. Pharmacopoeia and the National Formulary.

In every case, the complaint or suggestion was given careful consideration. If the dissatisfaction resulted from a misunderstanding, a letter of explanation was sent to the individual. Criticisms were acknowledged and will

continue to be used in planning future improvements of our program.

Since the partial results of this survey were mentioned in an address at a meeting of the Alabama Hospital Association, many requests for additional information have been received from Blue Cross plans, hospital councils, and similar groups. The following details of procedure may be of interest to those who wish to conduct a similar program.

When the Hospital Service Association of Pittsburgh was planning this survey, its primary aim was to obtain the opinions of recently hospitalized subscribers whose impressions would be fresh in their minds. The survey form, as reproduced here, was mailed with a copy of the hospital statement which each hospitalized member gets.

A statistical analysis was made when 5378 questionnaires had been returned, and a second study was completed from the next 3973 replies. A cumulative study was based upon the total of 9351 returns. A fourth study involved only 649 replies, and the final

statistics were based on a total of 10,000 questionnaires. A comparison of the five sets of percentage figures on each of the eight questions revealed an average variance of less than 1 per cent, satisfying the association that its results were statistically sound and could be applied to any given group of Blue Cross admissions.

Although the individual's occupation was not specifically requested, it was possible to determine that replies came from a wide variety of occupational pursuits. These included industrial workers, housewives, doctors, dentists, nurses, army and navy personnel, lawyers, judges, factory and clerical workers, store clerks, undertakers, mechanics, retired and self-employed individuals, ministers, teachers, truck drivers, hospital employees, college students, and government employees.

Their response to this survey lends the strength of numbers to the comment of one subscriber. "My Blue Cross card," he wrote, "is the most valuable card in my wallet."

Group No.:		
Contract No.:	Date	19
(As shown on attached hospital statement)		
I received Blue Cross benefits at _____ Hospital.		
(Address)		
Please answer the following questions frankly. Your name will not be used without your permission.		
1. Would you have gone to the hospital if you were not a Blue Cross member?	Yes	No
2. Would it have been difficult or impossible to have paid your hospital bill without the Blue Cross benefits provided?	Yes	No
3. Did you employ a nurse?	Yes	No
4. If so, was this additional service made possible by the fact that Blue Cross had relieved you of other financial obligations?	Yes	No
5. Were you satisfied with the services rendered?	Yes	No
6. Will you recommend Blue Cross membership to your friends?	Yes	No
7. Do you have the protection of Blue Shield, the non-profit plan for medical and surgical care?	Yes	No
8. If not, may we send you more information about it?	Yes	No
OTHER COMMENTS:		

Mr./Mrs./Miss	_____	
Street	City & Zone	
FOR BLUE SHIELD INFORMATION PLEASE COMPLETE THE FOLLOWING:		
I am:		
Unemployed ()		
Self-employed ()		
Employed by _____		
whose address is _____		
Approximate number of employees _____		
You have my permission to publish my name. Yes () No ()		

Questionnaire sent out; on the other side of the sheet was a transmittal letter.



**preoperatively
to reduce
morbidity following
vaginal hysterectomy**

Significant reduction in postoperative morbidity and complications is readily achieved by preoperative use of Bacitracin Vaginal Suppositories-C.S.C.

In a recent study,* it was shown that a single suppository containing 10,000 units of bacitracin, inserted deep into the vagina after the cleansing enema is expelled, greatly reduces the number of gram-positive pyogenic cocci, diphtheroids, and lactobacilli. Clinically, patients receiving the bacitracin suppository showed a significantly lowered postoperative morbidity as compared with the untreated controls. In the treated group, virtually all types of gynecologic surgery were included.

Bacitracin Vaginal Suppositories-C.S.C. contain 10,000 units of bacitracin in an inert soluble base. They are wedge-shaped to facilitate insertion and retention. Because of the low allergenic potentialities of bacitracin, this preparation is especially advantageous for routine hospital use. Supplied in boxes of 10 suppositories, each individually sealed in foil. Refrigeration is not required.

*Turner, S. J.; Wacker, M. N.; Goldin, H., and Auerbach, H.: The Effect of Bacitracin Suppositories on the Vaginal Flora and on Morbidity in Vaginal Hysterectomies. Submitted for Publication.

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SUPPOSITORIES**

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CHEST X-RAYS on Admission Pay Off—

to patients, hospital staff, and community

ROUTINE chest x-ray examination of patients admitted to general hospitals is a fruitful method of finding new cases of pulmonary tuberculosis. The patient, the hospital staff, and the community all reap benefits. As a routine procedure it yields greater returns in discovering unsuspected disease and disability than do mass x-ray examinations of the general population or school groups.

In New York State, outside of New York City, there are 166 voluntary, nonprofit and publicly supported general hospitals which annually admit more than 650,000 patients. The plan prepared by the New York State Department of Health and supported by public funds was developed cooperatively through the health department and these hospitals.

PROCEDURES IN EFFECT

Policies and procedures were set up in 1946 and briefly are as follows:

Any nonprofit general hospital with an inpatient admission rate sufficiently large to provide 4000 admission chest x-ray tests annually is eligible to borrow complete photofluorographic equipment for taking 4 by 5 inch or 70 mm. films. The hospital receives 50 cents for each report of an admission x-ray film submitted to the local health department. The department recommends that hospitals install equipment as close to the admitting rooms as practicable so as to maintain a high percentage of x-ray examinations on admitted patients.

Hospitals whose admission rate is less than 4000 patients annually may also participate in the program by using their own equipment. For this service, they receive \$1 for each x-ray report submitted. Of the 166 general hospitals, 58 are eligible for loan of photofluorographic equipment and the remaining 108 can participate by using

their own equipment. The 58 hospitals eligible for loan of equipment represent only 37 per cent of all the hospitals, but account for 67 per cent of all the admissions.

Any interested and eligible general hospital, willing to participate, submits an application to the state health department in which it agrees to certain conditions, as follows:

1. Make every effort to make x-ray examinations of the chests of all admitted patients, 15 years of age and over, including private patients.

2. Examine the chests of all employees not previously x-rayed and of all new employees.

3. Make no charge to the patient for the initial x-ray examination and interpretation or for any additional x-ray and laboratory examinations necessary to establish a diagnosis of tuberculosis.

4. Use the diagnostic classification recommended by the department.

5. Submit an x-ray report for each patient and employee examined under this program to the local health official.

When the program was first launched, instead of providing complete equipment, an eligible hospital was asked to accept only the photographic part of the equipment which was to be attached to its existing x-ray machine. It soon became apparent that this did not work well, mainly because it interfered with the routine functioning of x-ray departments. So the early plan was modified. In its stead, complete photofluorographic equipment

was made available. Furthermore, the particular type of equipment which was requested by the hospitals was supplied provided it was one of the four or five recognized standard makes of x-ray equipment. Once this policy became effective, there was greater interest and participation of the general hospitals. Many hospital directors, roentgenologists, and medical staffs need further enlightenment on the value of routine chest x-rays on admission, demonstrable in better diagnosis and reduced costs for care of tuberculous employees picked up in the net.

FILMS PROCESSED IN 24 HOURS

With each hospital functioning under its own plan of general operations, it was not expected that uniform procedures for the routine examination of admissions would be possible for all the hospitals. In general, however, the following routine was suggested and is being carried out with minor changes:

Identifying information is entered on a special report form at the time of admission for every patient 15 years of age or over. If the patient is physically able, he is examined by x-ray, usually without having to remove his clothing, before being taken to his ward or room. If he is too ill to be tested on admission, this is done as soon as his physical condition permits. The admission films, 4 by 5 inches, 70 mm. or 14 by 17 inches, are processed and interpreted within 24 hours and the diagnoses, if negative or non-tuberculous, are checked under the

WILLIAM SIEGAL, M.D.

ROBERT E. PLUNKETT, M.D.

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All of New York State Department of Health, Albany

for greater economy
for ease of application
for same high Bay quality

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ADHESIVE PLASTER, U.S.P.



BAY QUALITY

BayConomy provides an adhesive plaster prepared in conformity with exacting pharmaceutical and governmental standards. Cohesive strength, quick tack, and comfort to the user—always characteristic of BayHesive—are found in the new BayConomy.

ECONOMICAL

Additional saving to you is provided by a lighter weight backing cloth that combines adequate strength with greater pliability. The same fine grade adhesive mass used in BayHesive is retained—only the weight of the backing cloth has been changed.

**BAY DIVISION
PARKE, DAVIS & CO.
BRIDGEPORT, CONNECTICUT**

BayConomy is supplied in cuts of $\frac{1}{4}$ ", $\frac{1}{2}$ ", 1", $1\frac{1}{4}$ ", 2", 3", 4", and Dispensary and Operating Room Assortments in white. Also available in flesh color in $\frac{1}{2}$ ", 1", $1\frac{1}{4}$ ", 2", 3", 4", and Dispensary Assortment.

FIGURE 1. ADMISSION CHEST X-RAY REPORT

NEW YORK STATE DEPARTMENT OF HEALTH ROUTINE CHEST X-RAY REPORT GENERAL HOSPITALS		
HOSPITAL _____		CITY _____
PATIENT'S NAME _____		
LAST	FIRST	MIDDLE
HOME ADDRESS _____		
STREET OR RD. NO. _____		
TOWN, VILLAGE OR CITY _____		
AGE _____	SEX <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> INPATIENT <input type="checkbox"/> OUTPATIENT <input type="checkbox"/> EMPLOYEE
X-RAY NUMBER _____		DATE OF X-RAY _____
PROVISIONAL DIAGNOSIS <input type="checkbox"/> NEGATIVE		
TUBERCULOSIS		
1. <input type="checkbox"/> PROBABLY ACTIVE	2. <input type="checkbox"/> PROBABLY INACTIVE	OTHER CONDITIONS
<input type="checkbox"/> MINIMAL	3. <input type="checkbox"/> SUSPECT	1. <input type="checkbox"/> CARDIOMEGALY
<input type="checkbox"/> MOD. ADVANCED	4. <input type="checkbox"/> PLEURAL EFFUSION	2. <input type="checkbox"/> NONSPEC. INF.
<input type="checkbox"/> FAR ADVANCED		3. <input type="checkbox"/> NEOPLASM
		4. <input type="checkbox"/> FIBROSIS
		5. <input type="checkbox"/> OTHER
PRIVATE PHYSICIAN'S NAME _____		
(ENTER ONLY IF DIAGNOSIS IS TUBERCULOSIS)		

proper headings on a special report form (Figure 1).

If the admission film shows definite or suspected tuberculosis, additional chest x-ray examinations on standard size film and any other necessary examinations are made for more nearly accurate diagnostic and clinical evaluation, and that diagnosis is entered on the admission x-ray report. Completed admission x-ray reports are sent as frequently as practicable, but at least once weekly, to the health officer of the area in which the hospital is located. In addition, the hospital also furnishes the health officer with a monthly bill for the number of admission chest x-ray reports submitted to him. If active tuberculosis is found, the hospital then makes an official case report.

If it is important for participating hospitals to follow a uniform procedure in making x-ray tests of admissions, it is just as important that these hospitals use the same classification of disease, especially as it relates to tuberculosis, in reporting the results of the interpretations of these x-ray films. This classification must be broad enough to cover the many phases of tuberculosis and yet simple enough to be easily applicable either to the findings on the initial survey films or to the subsequent reexamination on standard size film. It is emphasized that the admission small or large film diagnosis is not considered as the final diagnosis or determination of activity. Nevertheless, a tentative diagnosis is necessary because many patients whose

initial films show the need for further careful detailed study do not remain in the hospital long enough for such study.

It is important for the health officer to know what possible cases of tuberculosis return to the community from the hospital. Accordingly, tentative diagnoses are made on all initial films, small or large. If the tentative diagnosis is definite tuberculosis, an estimate of clinical status is also made, that is, whether the disease is probably active or probably inactive, and, if probably active, the extent of the disease is also noted, whether minimal, moderately advanced or far advanced. Films which are thought to indicate the presence of pleural effusion which cannot be explained by some other condition are considered to be due to probably active tuberculosis.

The follow-up of cases of definite and suspected tuberculosis found by the hospital are the health officer's responsibility. The admission x-ray reports serve the health officer in three ways. First, he checks the number of reports which he receives against the number billed by the hospital for reimbursement. Second, he prepares monthly reports of the admission x-ray interpretations by age, sex and diagnosis for each hospital and lists the name, address, age and diagnosis of all patients with definite or suspected tuberculosis. These tabulations, together with the approved bills from the hospital, are sent to the division of tuberculosis control of the state department of health. Last, the health officer sets

up a separate file of positive x-ray reports. As for all reports of tuberculosis coming to the health officer from any other source, he arranges for necessary follow-up examinations. These include provision for diagnostic and clinical determination as soon as possible for each person reported and adequate medical care.

For each report of a definite or suspected case of tuberculosis resulting from the hospital admission x-ray program, the health officer submits to the department at the end of six months a summary of what has happened to the person during the interval. Were follow-up examinations made? If so, how did the final diagnosis and clinical status compare with the findings on admission? If tuberculosis was the final diagnosis, is the patient receiving hospital, clinic or home supervision? A six-month period may appear to be a long time for follow-up, but some cases actually take that long and longer, unfortunately for the patient.

This is an analysis of the initial chest x-ray examinations of adults admitted to the general hospitals participating in this program from May 1947 to January 1950. In addition, for patients who were admitted to the participating hospitals any time between January 1948 and June 30, 1949, and whose initial x-ray examinations indicated the presence of definite or suspected tuberculosis, an analysis is also presented showing at the end of six months how many have been followed up, what the final diagnosis proved to be in those who were followed up, and, finally, how many were receiving medical or public health nursing supervision or hospital care. The follow-up tabulations relate only to the 18 month period between January 1948 and June 1949 because the follow-up procedures were not yet functioning smoothly for the relatively few patients found in 1947, and a six-month period had not yet elapsed at the time of this report for the patients found during the last half of 1949.

During May 1947 through December 1949, 41 hospitals submitted reports of 195,751 patients, 15 years of age or over, who were given x-ray examination on admission. (The distribution of these patients by age, sex and diagnosis is shown in Table 1.) For all ages there were slightly more than twice as many females as males. This may be due to the great preponderance of females during the



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Table 1—Distribution of Chest X-Ray Examinations by Diagnosis* According to Age and Sex
General Hospital Routine Admission X-Ray Program
New York State 1947-49

Age	Sex	Number X-Rayed	Number					Number per Thousand X-Rayed				
			Tuberculosis					Tuberculosis				
			Total	Prob. Active	Prob. Inactive	Sus- pected	Other Conditions	Total	Prob. Active	Prob. Inactive	Sus- pected	Other Conditions
All ages	total	195,751	3,976	1,005	1,853	1,118	27,642	20.3	5.1	9.5	5.7	141.2
	male	61,867	2,056	607	920	529	12,469	33.2	9.8	14.9	8.6	201.5
	female	133,884	1,920	398	933	589	15,173	14.3	3.0	7.0	4.4	113.3
15-24	total	45,082	336	93	100	143	2,390	7.5	2.1	2.2	3.2	53.0
	male	8,560	91	34	22	35	535	10.6	4.0	2.6	4.1	62.5
	female	36,522	245	59	78	108	1,855	6.7	1.6	2.1	3.0	50.8
25-34	total	50,965	580	156	221	203	2,992	11.4	3.1	4.3	4.0	58.7
	male	9,912	163	67	50	46	766	16.4	6.8	5.0	4.6	77.3
	female	41,053	417	89	171	157	2,226	10.2	2.2	4.2	3.8	54.2
35-44	total	30,850	621	168	262	191	3,025	20.1	5.4	8.5	6.2	98.1
	male	10,194	257	87	88	82	1,285	25.2	8.5	8.6	8.0	126.1
	female	20,656	364	81	174	109	1,740	17.6	3.9	8.4	5.3	84.2
45-54	total	24,483	697	201	335	161	4,538	28.5	8.2	13.7	6.6	185.4
	male	10,699	418	144	179	95	2,198	39.1	13.5	16.7	8.9	205.4
	female	13,784	279	57	156	66	2,340	20.2	4.1	11.3	4.8	169.8
55 or over	total	41,366	1,699	380	909	410	14,330	41.1	9.2	22.0	9.9	346.4
	male	21,666	1,103	273	565	265	7,528	50.9	12.6	26.1	12.2	347.5
	female	19,700	596	107	344	145	6,802	30.3	5.4	17.5	7.4	345.3
Age not stated	total	3,005	43	7	26	10	367	14.3	2.3	8.7	3.3	122.1
	male	836	24	2	16	6	157	28.7	2.4	19.1	7.2	187.8
	female	2,169	19	5	10	4	210	8.8	2.3	4.6	1.8	96.8

*Tabulations are based on admission chest x-ray interpretation.

childbearing age groups, 15 to 34. These age groups, incidentally, account for 48 per cent of the entire group. Among the males, however, only 30 per cent of the patients were 15 to 34 years of age and 54 per cent were 45 years of age or older, a proportion almost twice that found in mass x-ray surveys.

In 3976 patients, or 20.3 for every thousand examined, there was x-ray evidence of definite or suspected tuberculosis. Of these, 1005 were tentatively diagnosed as probably active, 1853 as probably inactive, and 1118 as suspicious for tuberculosis, for rates of 5.1, 9.5 and 5.7 respectively, for every thousand patients tested.

For both sexes and for each sex separately, there is a progressive increase with age in the number of cases of probably active tuberculosis diagnosed per thousand persons examined, but the rate of increase with increasing age is far greater for males than for females. There is one exception to this in that there is a slight drop for males between 55 and 64 as compared to males between 45 and 54.

For all ages and for each age group separately, the yield of probably active tuberculosis was between two and one-

half to three and one-half times greater among males than among females. Thus, while the number of females examined was more than twice the number of males, more than one and one-half times as many cases of probably active tuberculosis were found among males. No such wide differences exist between the sexes for probably inactive tuberculosis.

Of the probably active tuberculosis cases, 47 per cent were minimal, 35 per cent were moderately advanced, and 18 per cent were far advanced.

It is interesting to compare the yields and distribution by stage of disease of probably active tuberculosis found in community chest x-ray surveys in New York State over a period of three years with the general hospital admission x-ray figures. In community surveys, the number of probably active cases has ranged between 2.5 to 3 for every thousand examined. For general hospitals the corresponding number is 5. In community surveys considerably more than half the probably active cases have been classified as minimal. Among general hospital admissions less than half have been minimal.

As mentioned previously, the an-

alysis of the results of follow-up of patients found to have definite or suspected tuberculosis on admission was limited to the admission period between January 1948 and June 1949, inclusive. During that period reports were received of 126,190 admission x-ray examinations, among which 2642 cases of definite or suspected tuberculosis were diagnosed, or 21 per thousand patients tested. (The distribution of these cases according to whether they had been previously reported as tuberculosis cases to the health department by clinical status and stage of disease is shown in Table 2.) Of the total cases, 2145, or 81 per cent, had not been previously reported and were therefore presumably new. Of the probably active cases initially diagnosed, 64.1 per cent were new.

Reports received from the different local health departments of the status of these 2145 cases six months after the initial hospital diagnosis showed that only 1537, or 71.7 per cent, had had any follow-up examinations. There are no records of any follow-up examinations of the remaining 608, more than half of which, or 311, came from the group initially diagnosed as prob-

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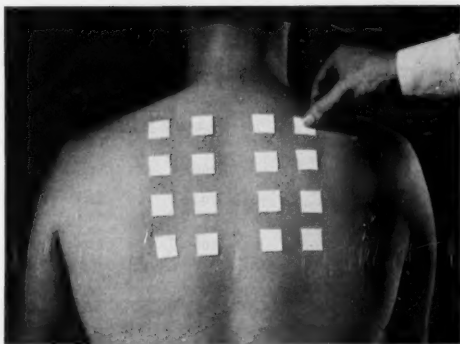
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Table 2—Distribution of Tuberculosis Cases According to Previous Report to Health Department General Hospital Routine Admission Chest X-Ray Program January 1948—June 1949

Initial Hospital Diagnosis	Total		Previously Reported		Not Previously Reported	
	Number	per Cent	Number	per Cent	Number	per Cent
Total tuberculosis.....	2,642	100.0	497	18.8	2,145	81.2
Probably active.....	704	100.0	253	35.9	451	64.1
Minimal.....	188	100.0	47	25.0	141	75.0
Moderately advanced.....	255	100.0	131	51.4	124	48.6
Far advanced.....	122	100.0	70	57.4	52	42.6
Pleural effusion.....	139	100.0	5	3.6	134	96.4
Probably inactive.....	1,198	100.0	176	14.7	1,022	85.3
Suspected.....	740	100.0	68	9.2	672	90.8

Table 3—Follow-up Diagnosis of Unreported Cases by Initial Hospital Diagnosis General Hospital Routine Admission Chest X-Ray Program January 1948—June 1949

Initial Hospital Diagnosis	Follow-up Diagnosis											
	Tuberculosis											
	Total		Total		Active		Activity Undetermined		Inactive		Suspected	
	Number	per Cent	Number	per Cent	Number	per Cent	Number	per Cent	Number	per Cent	Number	per Cent
Total tuberculosis.....	1,537	100.0	855	55.6	181	11.8	21	1.4	590	38.4	63	4.1
Probably active.....	336	100.0	186	55.4	118	35.1	9	2.7	52	15.5	7	2.1
Minimal.....	95	100.0	65	68.4	32	33.7	5	5.3	26	27.4	2	2.1
Mod. advanced.....	97	100.0	73	75.3	46	47.4	3	3.1	20	20.6	4	4.1
Far advanced.....	33	100.0	28	84.8	23	69.7	1	3.0	5	15.2	1	3.0
Pleural effusion.....	111	100.0	20	18.0	17	15.3	1	0.9	1	0.9	1	0.9
Probably inactive.....	711	100.0	480	67.5	21	3.0	4	0.6	445	62.6	10	1.4
Suspected.....	490	100.0	189	38.6	42	8.6	8	1.6	93	19.0	46	9.4

Table 4—Disposition Status of New Tuberculosis Cases After Follow-up General Hospital Routine Admission Chest X-Ray Program January 1948—June 1949

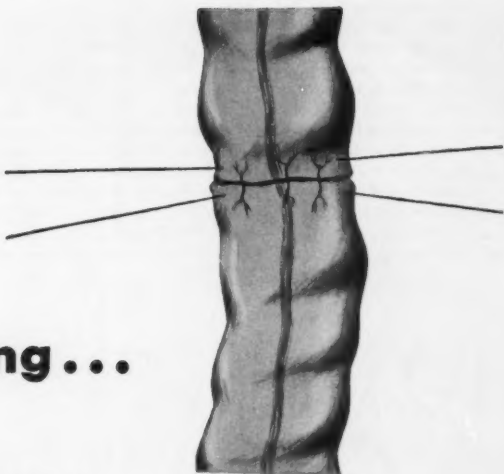
Final Diagnosis After Follow-up	Disposition Status Known										
	Type of Supervision for Those Remaining in Community							Died		Dis- position	
	Total	Total	In TB Hosp.	TB Clinic or P.H.N.	Private Physician	None	No Supervision Recom- mended	TB	Other Cause	Cause Unknown	Status Unknown
Total tuberculosis.....	855	548	62	223	106	6	110	9	24	8	307
Active.....	181	134	59	38	15	2	...	9	7	4	47
Activity undetermined.....	21	15	...	12	3	...	...	...	...	...	6
Inactive.....	590	347	1	148	79	4	110	...	4	1	243
Suspected.....	63	52	2	25	9	...	...	...	13	3	11

ably inactive. However, 27 per cent of the suspects and 25 per cent of the probably active cases had not had follow-up examinations at the end of six months. This may be a reflection of the fact that satisfactory facilities for field supervision and follow-up of

cases are not yet uniformly available over the entire state. The rôle of the general practitioner in speed and completeness of follow-up requires further study and will be done this year.

A comparison of the final diagnosis after follow-up examination with the

initial admission diagnosis of the 1537 new cases who had follow-up examinations is of interest and concern. It is significant that in only 885 (or 55.6 per cent) of this group was there confirmation of definite or suspected tuberculosis after follow-up. In only



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35 per cent of those initially diagnosed as probably active was there confirmation after follow-up. Altogether 181 cases were diagnosed as active. Eighty of these were culled from those initially not diagnosed as such in the hospital. Pleural effusion, suspects or probably inactive disease were the more frequent diagnoses. In other words, 44 per cent of the active cases finally diagnosed would not have been found if follow-up examinations of suspects had not been made. In addition to the 181 definitely active cases found after follow-up, another 21 were

considered to be tuberculous, but determination of activity had not yet been made, and still another 63 patients were considered as suspicious for tuberculosis even after follow-up study. This is the total of 84 patients whose clinical status was undetermined or for whom a definite diagnosis of tuberculosis had not yet been made.

How many of these 84 eventually would be diagnosed as having active tuberculosis cannot be stated with accuracy. But, if after six months no exact determination had yet been reached, we would estimate on the

basis of previous experience that half of these (or 42) would eventually be labeled as active cases of tuberculosis. To the 181 definitely active cases on record might be added these 42 for a total of 223 active cases which would finally result from the field follow-up examinations of the 1537 new cases initially diagnosed definite or suspected tuberculosis. Applying the ratio of 223 active cases out of 1537 followed up to the 2145 total new cases initially diagnosed, there is a possible yield of 311 active cases of tuberculosis, or a rate of 2.5 active cases of tuberculosis for every thousand patients examined by x-rays.

(The disposition status of the 855 cases diagnosed definite or suspected tuberculosis after follow-up examinations is shown in Table 4.) Of the total of 855 cases of definite or suspected tuberculosis (diagnosed on the basis of follow-up study), 181 were active cases, 21 were diagnosed as tuberculous but activity was still undetermined, 63 were still considered as suspicious for tuberculosis, and 590 were diagnosed inactive tuberculosis. At the end of six months, 62 of the 855 cases were hospitalized, 223 were under clinic or public health nursing supervision, 106 were under private medical supervision, and 41 had died, only nine of the latter because of tuberculosis.

In another 110, further medical or public health nursing supervision apparently was not recommended, which is understandable since these 110 came from the group finally diagnosed as having inactive tuberculosis. There was also a small group of six patients who were known to be at home but who were not under supervision either because it was not indicated or was refused. There is thus a total of 558 patients out of 855 for whom there are available not only the final follow-up diagnoses but also information as to what has become of them with regard to survival, treatment or supervision.

Inasmuch as the supervision of the active cases is a fundamental part of tuberculosis control, the greatest interest centers around what happened to the 181 active cases in that group. Fifty-nine, or about one-third, were hospitalized; 38 and 15 respectively, or a total of 53, were under public health or private medical supervision; 20 were dead, nine of these with tuberculosis as the cause of death; two patients were at home and apparently



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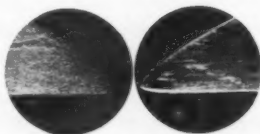
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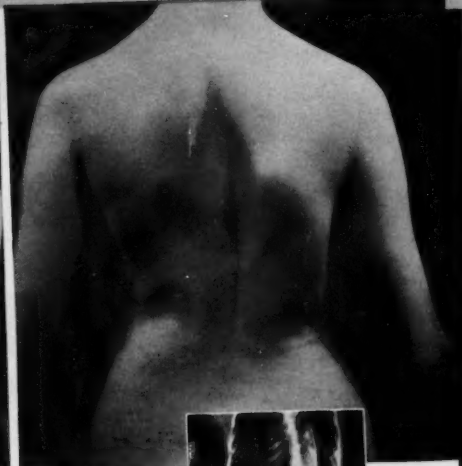
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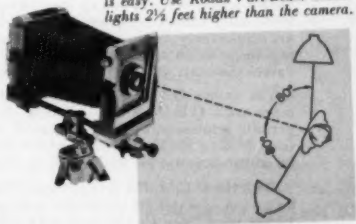
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refused or required no supervision. For the remaining 47, information of the disposition status is not available. Thus of the 161 active cases still alive at the end of six months, 112, or 70 per cent, were under public health or private medical supervision. On the basis of the number of patients actually hospitalized, the ratio is one patient hospitalized for every 2000 admissions examined.

From the experience in New York State during the last three years, the yield of definite or suspected tuberculosis is twice as high among general

hospital patients (20 per 1000) as it is in the general population (10 per 1000). The same holds true for the yield of probably active tuberculosis. Among those called probably active, there are more moderately and far advanced cases of tuberculosis in hospital admissions than there are in community surveys. There is a higher percentage of cases previously reported to the health department from the general hospital program than from community surveys. However, one must point out that every case of hidden tuberculosis in a general hospital

may well be a menace regardless of whether it has been previously reported.

While this report concerns itself primarily with tuberculosis, the discovery of nontuberculous, intrathoracic conditions is worth mentioning. A useful by-product of the tuberculosis case-finding program was the detection of nontuberculous conditions in the thorax. Intra-thoracic tumors and heart disease made up a large share of the 14.1 per cent of the abnormal chest films that were nontuberculous.

While no brief is necessary at this time to justify the routine chest x-ray examination in general hospitals, perhaps one additional benefit should be emphasized. Such a program, successfully administered, provides an easy means of obtaining the x-ray examination of a good many individuals past middle age. The most difficult part in the conduct of a mass survey is getting the older people to participate. One should recall that it is among the older people, especially males, that tuberculosis and cancer of the lungs are more frequently found.

It might be supposed that in a program like this in general hospitals where presumably highly trained personnel and modern facilities are available there would be a high degree of accuracy in the diagnostic and clinical evaluation of patients whose x-ray films show varying types of abnormal shadows. The results of the follow-up examinations after such patients have been discharged do not bear this out. In only 56 per cent did the follow-up studies confirm the hospital diagnosis of definite or suspected tuberculosis.

This program, however, is still relatively new. Most of the 41 hospitals, whose data form the basis of this report, have been making x-ray examinations of admissions for only one year or less. It takes time before there is complete understanding of the policies and procedures of a new program and for its smooth operation. To narrow this gap between the initial admission and final follow-up diagnosis, the hospitals are urged to avail themselves of the services in their areas of physicians with special training in chest diseases, usually on the staffs of local tuberculosis hospitals or health departments. In one of the hospitals where such follow-up arrangements were made, there was confirmation of the original diagnosis in 71 per cent of the cases, significantly higher than the 56 per cent found for the group as a whole.

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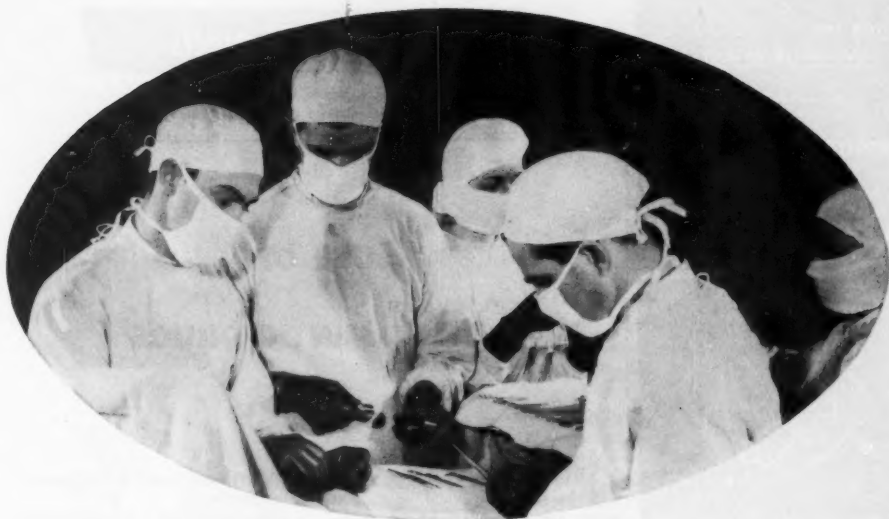
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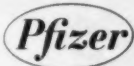
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500 mg. in 20 cc. vials

Also supplied as Elixir, Oral Drops, Ointment, Ophthalmic Ointment, and Ophthalmic Solution.

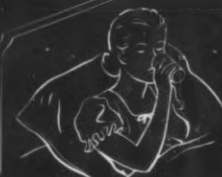
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A Laxative for Judicious Therapy

ACCEPTED FOR ADVERTISING BY THE JOURNAL
OF THE AMERICAN MEDICAL ASSOCIATION

Notes and Abstracts

Prepared by the Committee on Pharmacy and Therapeutics
University of Illinois College of Medicine, Chicago 12

USE OF

ANTHELMINTIC DRUGS

DRUGS that are capable of ridding human beings and animals of worm infestations are known as anthelmintic agents. Certain types of infestation occur throughout the world; among these are pin-worms, muscle-worms, roundworms and tapeworms. Hookworm disease is prevalent in semi-tropical regions, as in our own South. Eel-worm infestation is confined to the tropics.

On the next text page appears a table giving the common types of worms that infest the human body, the symptoms they provoke, aids in diagnosis, drugs that are effective for each type and the recommended dosage for adults and for children, the toxicity of the drugs prescribed, and the catharsis that should precede or follow administration of the anthelmintic agent.

Gentian Violet Medicinal (Methyl-rosaniline) produces only local irritation of the G-I tract and none is absorbed. The adult dose should be reduced so that a three-year-old child receives 10 mgm. T.I.D. and a six-year-old patient would receive 20 mgm. T.I.D. If intolerance to the medication develops, therapy can be interrupted by a two-day rest. In the treatment of

pin-worms, the whole family must receive treatment.

Hexylresorcinol ("Caprakol" Sharp and Dohme) is safe, but not completely effective as an anthelmintic except against roundworms. If the hard gelatin capsule is broken the mucous membranes will become white and may desquamate. About one-third of the dose is absorbed from the intestine and eliminated in the urine after conjugation. Food buffers the toxic effect of the drug on the parasite, and therefore the dose should be given in the morning when the patient's stomach is empty.

Tetrachlorethylene is available in soft gelatin capsules, but may be mixed with watery vehicles or dropped on sugar for administration to children. Fats and alcohol should not be taken with tetrachlorethylene as these will promote absorption which is ordinarily negligible. The night before treatment a light meal is allowed followed by a purging dose of sodium sulfate. The proper dose for the patient is then given the following morning when the alimentary tract is relatively empty. Two hours later another saline purge is given and food is withheld until this purge has taken effect.

Oil of *Chenopodium* should be used only when other vermifuges fail since it is the most toxic of the agents commonly used for roundworms.

Aspidium may also produce severe intoxication and its use is therefore reserved for a proven tapeworm infestation. It has no value in other worm infestations.—C. C. PFEIFFER, PH.D., M.D.





MORE HOURS of Allergy Relief...

**8 to 24 from
a single dose**

Look in the file of clinical reports on antihistaminics and it will be apparent that one is outstanding for prolonged action. It is Di-PARALENE Hydrochloride (Chlorcyclizine Hydrochloride, Abbott), a "different" antihistaminic with a piperazine side chain rather than one of the conventional types.

Numerous clinical reports attest to the longer lasting allergy relief with Di-PARALENE. In many cases relief up to 24 hours can be obtained from a single dose. Initially, Di-PARALENE should be administered in 50-mg. doses three times a day for the average adult, but in the majority of cases this dosage can later be reduced to one or two doses a day. One 50-mg. tablet at bedtime often provides symptomatic relief through the night. Frequently, no additional dosage is required until the next bedtime. Undesirable side-effects are comparatively few and mild.

This season try longer-acting Di-PARALENE in your allergy cases. Available at prescription pharmacies in 50-mg. and 25-mg. tablets in bottles of 100 and 500. **Abbott**

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**Abbott's new long-acting
antihistaminic**

REFERENCES: Spielman, A. D. (1950), N. Y. St. J. Med., 50:2297, Oct. 1. Brown, E. A., et al. (1950), Ann. Allergy, 8:32, Jan.-Feb. Jenkins, C. M. (1950), J. Mat. Med. Assn., 42:293, Sept. Cutlick, Louis, and Ogden, H. D. (1950), South. Med. J., 43:632, July. Ehrlich, H. J., and Kaplan, M. A. (1950), Ann. Allergy, 8:682, Sept.-Oct.



THE USE OF ANTHELMINTIC DRUGS

WORM AND DISTRIBUTION	SCIENTIFIC NAME	SYMPTOMS	DIAGNOSIS	DRUGS	ADULT DOSE	CATHARTIS	DRUG TOXICITY
Pin-worm (Universal)	Enterobius Vermicularis	Severe Anal Pruritis	Scotch tape Slide of perianal region	Gentian violet (enteric coated)	65 mgm. T.I.D.	Not necessary	Nausea G-I irritation
			Ova in stool	Phenothiazine	4.0 Gm./day for 5 days	Not necessary	Nausea Diarrhea Vertigo
Earworm (Tropics)	Strongyloides Stercoralis	Bronchitis Enteritis Local edema	Male Larvae in stool	Gentian violet (enteric coated)	65 mgm. T.I.D.	Not necessary	Nausea G-I irritation
Whipworm (Tropics)	Trichocephalus Trichiuris	Toxemia Anemia	Parasites and ova in stool	Hezylre-sorcinol (coated)	1.0 Gm. (0.6 Gm. children)	Saline cathartic	G-I burning
				Tetrachlor-ethylene	3-4 cc. 0.2 cc./yr. of age	Saline cathartic	Vertigo
				Ficin*			
Muscleworm (Universal)	Trichinella Spiralis	Vomiting and diarrhea Muscle pain Local edema and fever	Parasites in stool Eosinophilia Leukocytosis	Hezylre-sorcinol (coated)	1.0 Gm. every 3 days	Saline cathartic	G-I burning
Hookworm (Semi-tropical)	Ancylostoma Duodenale Necator Americanus	Ground itch Anemia Nutritional Deficiencies	Ova in stool	Hezylre-sorcinol (coated) Tetrachlor-ethylene Ferrous salts for anemia	1.0 Gm. every 3 days 3-4 cc. 2-4 Gm.	Saline cathartic	G-I burning Vertigo
Roundworm (Universal)	Ascaris Lumbricoides	Abdominal pain	Ova in stool	Oil of Chenopodium	0.2 cc. to 1.5 cc.	No fasting*** Saline cathartic No oil	Constipation Clonic convulsion Coma
		Ascariis Pneumonitis		Santonin	0.2 to 0.3 Gm.	(Calomel?) (No oil) Saline purge	Colored vision Headache Vomiting
		Lumen Obstruction		Hezylre-sorcinol (coated)	1.0 Gm. every 3 days	Saline cathartic	Burning G-I tract
Tapeworm (Universal)	Taenia Saginata Taenia Solium Diphyllobothrium Latum Hymenolepis nana	Diarrhea Weight loss	Eosinophilia ova and segments in stools Identify head of parasites after treatment	Aspidium (Male Fern) Pelleterine Tannate	5.0 Gm. 0.5 Gm./yr. of age	Fasting and fat-free diet Saline purge before and after	Headache Vertigo Colored vision Blindness Muscle cramps Convulsion
					0.250 mgm.	Saline purge	Vertigo Curare-like action on muscles

*A proteolytic sap from a tropical fig tree which is very effective but not available outside of the tropics.
 **Severe migration of roundworms in patients with mixed infestations. (Hezylre-sorcinol alone is 0.5 Gm. only 75% of the hookworms.)
 ***4.0 Gm. of Oil of Chenopodium is 0.150 Gm. of Santonin. M.D. is 0.005 Gm. per 100 Gm. of body weight.
 The much more toxic carbon tetrachloride may be substituted for tetrachloroethylene. CC14 has been deliberately omitted from this table because of the occasional fatal intoxications which have occurred in children and alcoholics.

THE ANTIBIOTIC OF CHOICE *In Gram-Positive
and Gonococcic Infections:*

Penicillin

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MOST ECONOMICAL

UNSURPASSED IN
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PENICILLIN G MERCK
FOR AQUEOUS INJECTION**

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Food and Food Service

Conducted by Mary P. Huddleson

DRY MILKS are easy to use, easy to store

and an insurance against emergencies

HIGH nutritive value at low cost—that's the story behind the rapid rise in acceptance of nonfat dry milk solids in quantity food preparation. With costs going up and budgets shrinking in proportion, many institutional dietitians have found to their delight that they can maintain, and even increase, nutritive values of meals without spending more, and often at lower cost. The best part of their experience is that variety, appetite appeal, and flavor need not be curtailed in the process because dry milks used in food preparation are versatile and definitely quality improvers.

VALUABLE FORTIFIER

In a recent research bulletin,* Hugh L. Cook of the United States Bureau of Agricultural Economics, and Dorothy L. Hussemann of the University of Wisconsin, show clearly that the concentration of milk solids in four typical recipes can be increased substantially without impairing the acceptability of the foods. The substantial contribution of protein, calcium, riboflavin and other important milk solids is indeed of great significance in institutional menu planning. Of particular interest to hospitals where protein intake is frequently of such vital importance, the dry milks offer a most convenient and economical means of fortifying diets with substantial amounts of excellent quality milk protein.

The table of nutritional values indicates, in easy-to-use form, the dietary essentials of two important dry products of milk. Dry whole milk is fresh fluid milk from which only water is removed, while nonfat dry milk solids is the product resulting from removal of both fat and water. It is significant to dietitians that the process of drying

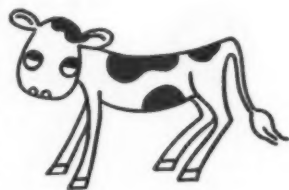
MADGE LITTLE
American Dry Milk Institute, Inc.
Chicago

the pasteurized milk or nonfat milk has no more effect on nutritive values than has milk pasteurization alone. Thus, drying merely converts important milk nutrients to a form which is easy to use, easy to store without refrigeration for continuous supply, and therefore a source of insurance against unexpected emergencies which might affect daily deliveries, and economical to purchase.

When dry whole milk or nonfat dry milk solids is added to a recipe, the food value is increased approximately as follows:

Dry Whole Milk	Nonfat Dry Milk Solids
1 oz. (3½ tablespoons)	1 oz. (4 tablespoons)
7.5 gms. Protein	10.5 gms.
10.9 gms. Lactose	14.5 gms.
7.6 gms. Fat	0.25 gms.
0.275 gms. Calcium	0.37 gms.
0.21 gms. Phosphorus	0.29 gms.
0.19 mg. Niacin	0.26 mg.
0.075 mg. Thiamine	0.10 mg.
0.42 mg. Riboflavin	0.57 mg.
141 Calories	102 Calories

In use, dry milks offer greatest advantage when used in dry form just like other staple ingredients. The following recipes show how, and while they feature nonfat dry milk solids, dry whole milk will work equally well in all but the whipped topping.



Macaroni Republic is a main dish that is simple to prepare and high in food value:

MACARONI REPUBLIC (50 Servings)

- 3 lbs. macaroni
- 3 oz. salt
- 3 gal. boiling water
- 1½ lbs. nonfat dry milk solids
- 1 lb. butter
- 2 14½ oz. cans pimientos
- 2 lbs. bread crumbs, day old
- 2 tbsp. salt
- 1 tsp. pepper
- 1 tsp. celery salt
- 1 tsp. mustard
- 5 lbs. cheese, shredded
- 3 doz. eggs
- 1¼ gal. water
- Paprika

Cook macaroni in boiling salted water 10-15 minutes or until tender. Drain well. Mix nonfat dry milk solids, butter, pimientos, bread crumbs, salt, pepper, celery salt, mustard, cheese, beaten eggs, and add hot water. Add macaroni. Place in 2 (9x15 inch) well greased baking pans. Sprinkle with paprika. Bake in slow oven (350° F.) until firm.

Nonfat dry milk solids is a natural binder for ground meat mixtures. It improves the texture, flavor and slicing qualities. It holds the moisture and prevents crumbling. The food value is increased, since nonfat dry milk solids contain complete proteins with a high percentage of riboflavin and calcium. It is possible to use as much as 15 per cent of nonfat dry milk solids in meat mixtures.

BAKED MEAT BALLS (50 Servings—Two to a Serving)

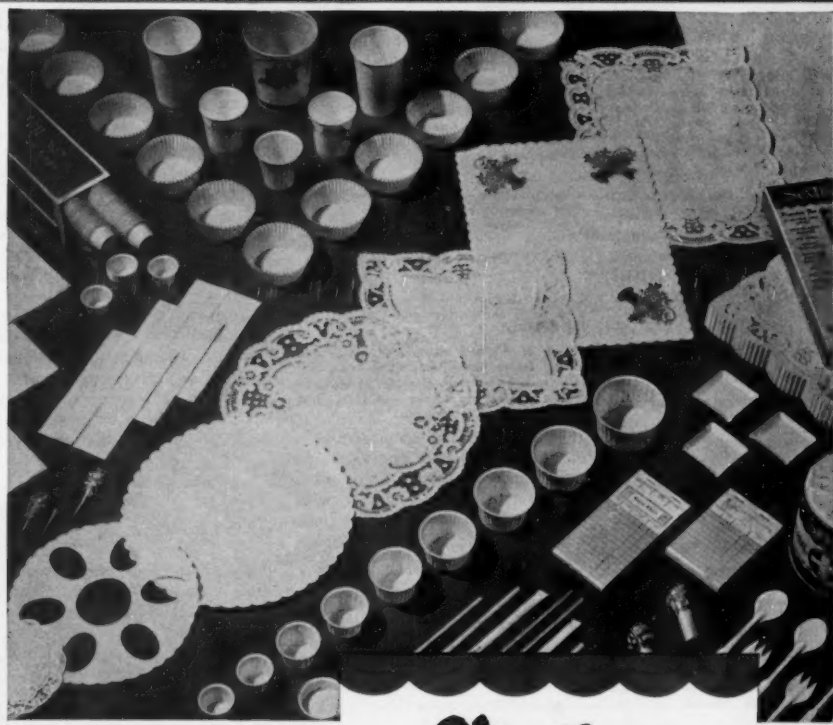
- 4 lbs. ground beef
- 4 lbs. ground pork
- 2 lbs. ground veal
- 1 qt. bread crumbs
- 3 cups nonfat dry milk solids
- 5 eggs (or equivalent in dried eggs)
- 4 tbsp. salt
- 1½ tsp. pepper
- 2 cups carrots, grated
- 3 cups water

Have meat ground fine. Mix ingredients in order given. Use No. 16 scoop to measure meat. Place in roasting pans. Cook in slow oven (325° F.) for 1 hour. May be covered with a gravy or mushroom sauce during last half hour of baking. [Other combinations of meat may be used.]

*University of Wisconsin Research Bulletin No. 164, January 1950.

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Sexton
Quality Foods

HAM LOAF (50 Servings)

8 lbs. cured ham, ground
4 lbs. fresh veal, ground
1 1/4 qt. fine bread crumbs
1 tbsp. salt
1 tsp. pepper
1 tsp. mustard
9 eggs (or equivalent in dried eggs)
2 cups nonfat dry milk solids
4 cups water

Mix ham with veal, add crumbs, salt, pepper, mustard, eggs, nonfat dry milk solids and water. Mix well. Mold into loaf pans and bake in slow oven (325° F.) for 1 1/4 hours.

SALMON LOAF (50 Servings)

9 1-lb. cans salmon (or other cooked fish)
1 1/2 cups onions, chopped
3/4 qt. bread crumbs
1 1/2 qts. celery, diced
1/4 tsp. paprika
3 tbsp. salt
3 cups eggs
2 cups nonfat dry milk solids
3 qts. water

Flake salmon, sauté onions. Combine with bread crumbs, diced celery and seasonings. Beat eggs, add nonfat dry milk solids, beat until smooth, add warm water. Add to above. Fill greased loaf pan. Bake in moderate oven (350° F.) for 45-50 minutes. Slice and serve.

Institutions as well as homemakers are becoming "mix minded" these days for obvious reasons. It is so simple to make a mechanical mixture with the standard equipment found in all institutions; then later any employee can be quickly trained to turn out products of high quality.

FOR MIX-MINDED DIETITIANS

The following mixes are scaled to fit a 30 pound lard can, which is an ideal storage container. No refrigeration is necessary.

BISCUIT MIX (19 1/2 lbs. or 15 3/4 qts.)

12 lbs. or 12 qts. sifted flour
2 1/4 lbs. or 2 1/4 qts. nonfat dry milk solids
9 oz. or 1 1/2 cups baking powder
6 tbsp. salt
4 1/2 lbs. or 2 1/4 qts. shortening

Blend dry ingredients in mixer using whip 15 minutes on low speed or sift together 3 times. Rub or cut in the fat. Store in a cool place in a tightly covered container.

BISCUITS (5 dozen)

3 lbs., or 9 1/2 cups dry mix
2 1/2 cups water

Weigh or sift and measure dry mix. Add water to make a soft dough. Turn out on a lightly floured board. Roll to 1/2 inch thickness and cut with a floured 2 inch cutter. Place on ungreased baking sheets and bake in hot oven (450° F.) 12 minutes.

BROWNIE MIX (15 1/2 lbs. of mix)

4 lbs. or 4 qts. sifted flour
1 1/2 lbs. or 1 1/2 qts. nonfat dry milk solids
12 oz. or 3 cups dried eggs
8 lbs. or 4 qts. sugar
1 lb. or 1 qt. cocoa
6 tbsp. baking powder
4 tbsp. salt

Blend all ingredients in mixer for 15 minutes or sift together 3 times. Store in a cool place, in a tightly covered container.

BROWNIES (3 Dozen)

3 lbs. or 7 1/8 cups dry mix
1 1/8 cups water
2 1/4 tsp. vanilla
9 oz. or 1 1/2 cups melted fat
6 oz. or 1 cup chopped nuts or raisins

Add water and vanilla to melted fat. Add liquid one-third at a time to dry mix, blending after each addition. Turn into greased baking pans and bake in moderate oven (350° F.) from 25-30 minutes. When cool cut into squares.

PLAIN MUFFIN MIX (17 lbs. or 14 qts.)

10 lbs. or 10 qts. sifted flour
12 1/2 oz. or 1 3/4 cups baking powder
5 lbs. or 2 1/2 qts. sugar
4 oz. or 1 1/2 cups dried eggs
15 oz. or 1 qt. nonfat dry milk solids
1 tbsp. salt

Blend ingredients in mixer, using whip 15 minutes on low speed or sift together 3 times. Store in a tightly covered container in a cool place.

PLAIN MUFFINS (4 Dozen)

3 lbs. or 10 cups dry mix
5 oz. or 3/4 cup melted fat
3 3/4 cups water

Weigh or sift and measure dry mix. Add melted fat to water. Add to dry mix. Stir sufficiently to moisten. Use No. 24 scoop to fill the greased and floured muffin tins. Bake at 400° F. for 20-25 minutes.

Whipped topping has many uses in the institution where food value and cost must be considered. It is possible in its use to incorporate large quantities of the nonfat dry milk solids in many dishes where one does not ordinarily expect to find any form of milk.

It may be folded into fruit and plain bavarian creams, fruit whips, lemon custard mixtures, salad dressings and whipped cream.

WHIPPED NONFAT DRY MILK SOLIDS TOPPING (1 1/2 Quarts)

2 cups water
1/4 cup lemon juice
2 cups nonfat dry milk solids*
1/4 cup sugar
1 tsp. vanilla

Put water and lemon juice in large bowl; add nonfat dry milk solids. Beat with a rotary beater until very stiff. Add sugar and vanilla.

*Use spray process only; roller process will not whip.

FOOD FOR THOUGHT

The Breakfast Egg

The egg shines more brightly than ever in the breakfast spotlight since research has shown that a breakfast containing a good deal of protein, and some in particular of top-quality, can do more for the eater's sense of well being and stave off fatigue hours longer than a morning meal that is poor in protein.

Soft or hard-cooked, poached, shirred, fried, scrambled . . . having an egg, or eggs, for breakfast is one way to tuck in some high-grade protein for body "building and repair," say nutritionists of the U.S. Department of Agriculture.

To show a few breakfast combinations that include eggs and do well by protein and other nutrients, the food specialists suggest these—adding that it is well to feature citrus as breakfast fruit because of its richness in vitamin C:

Fruit; egg; bread; milk; other beverage, if desired.

Fruit; egg; ham, bacon or sausage; bread or pancake; milk; other beverage, if desired.

Fruit; cereal with milk; egg; bread; beverage.

According to the National Research Council's yardstick of good nutrition, 60 grams of protein are recommended daily for an average-sized woman; 70 for a man. For young children, the amount rises from 40 grams at 1 to 3 years to 70 grams at 10 to 12 years.

Food Improvements

Whatever new foods may be developed in the next decade, they are likely to offer greater convenience, more natural flavor, higher nutritive value and lower relative cost, predicts John H. Kilbuck, food technologist of the California Experiment Station.

Reviewing trends in food production in the last 10 years, Mr. Kilbuck says that though no major new foods have been developed, great strides have been made in improving foods already in use.

The easy utility or convenience of a food product has much to do with its popularity with consumers. Prepared mixes and frozen citrus concentrate are examples of products which have had widespread and rapid sale because of the convenience factor. Research in new methods and ma-

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The 2-slice "Toastmaster" Toaster (upper left) pops up 125 slices per hour; the four-slice (lower left) has an hourly capacity of over 250 slices. You buy the size you need now; then, as requirements grow, it's easy to add a unit that will satisfy any toasting needs—all the way up to 1000 slices of golden brown toast per hour.

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†Prices subject to change

chinery for farming and food processing promise lower relative costs of food.

Food scientists also have been working to improve processing, shipping and storage so that foods will hold more of their natural flavor, color and texture. Frozen fruit juice concentrates and a new milk concentrate are products of a low temperature evaporation method developed during World War II.

Research also is pointing the way to varieties of fruits and vegetables of higher nutritive value, as well as

to new commercial food products offering more of the essential vitamins, minerals and often protein.

Tea Imports

More tea was imported by the U.S. last year than in any year since 1918 when World War I stockpiling accounted for large takings, notes the Office of Foreign Agricultural Relations, U.S. Department of Agriculture. Total tea imports in 1950 tipped the scales at more than 114½ million pounds, compared to 94.9 million pounds in 1949, 91.4 million pounds

in 1948, and 88.9 million pounds as the 1935-1939 average. The big jump in imports last year probably resulted from higher coffee prices and large-scale advertising of tea. Price-conscious housewives also may have been influenced by the fact that a pound of tea can make about four times as many cups of the beverage as does a pound of coffee. Also, the price of tea has risen little compared to that of many commodities. However, the U.S. is still a coffee-drinking country. Last year per capita consumption was 16 pounds of coffee compared to less than 1 pound of tea.

Asia supplied about 92 per cent of the tea imports last year, the rest coming from Africa. Ceylon ships more to the U.S. than does any other country, with India and Indonesia ranking second.

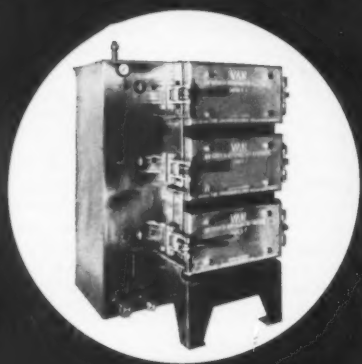
Protein for Dessert

The main course of the meal is the usual place for the high protein dish, but when eggs are plentiful and inexpensive a protein dish can come last—for example, a generous egg dessert like custard or pound cake. Some of the most delicious desserts are lavish in eggs.

Baked custard can be touched up so that each serving is different, according to cookery specialists of the U.S. Department of Agriculture. An easy way to do it is to line up six custard cups and put a few raisins in one, nutmeg in another, cooked dried apricots in a third, honey in a fourth, chocolate chips in a fifth, then fill all six cups with the custard mixture and bake. When done, this assortment is turned upside down in individual dessert dishes so that the trimmings are on top. The one plain custard may be touched up with frozen strawberry sauce at serving time. The specialists say that greasing the custard cups helps make apricots or nutmeg stay in place.

The baked custard recipe used for this assortment calls for: ¼ cup sugar; ¼ teaspoon salt; 3 eggs, beaten; 2 cups hot milk; 1 teaspoon vanilla. To make, combine sugar, salt and eggs. Add milk slowly, then vanilla. Pour into custard cups and set in a pan of hot water. Bake in a slow oven (325 F.) until custard is set—30 or 40 minutes.

When egg prices are down, here's a five-egg loaf cake worth considering: *Ingredients*—1 cup fat; 1 cup sugar; 1 teaspoon grated lemon rind; 2 table-



Van's contribution to hospital food service

★ The newest Automatic Van Steam Cooker, illustrated above, built with hospital needs in mind is an excellent example of Van's contribution. Van has pioneered with better food service equipment as new arts and metals have developed. Ask for the new Van Steamer Bulletin Sa.

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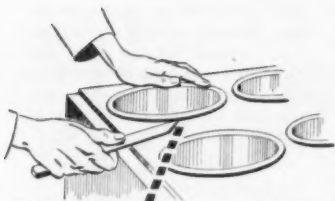
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... BECAUSE THERE ARE NO CREVICES



ORDINARY CONSTRUCTION
showing food conveyor top with crevices around each well.

● In ordinary food conveyor construction, wells are separate units, forming crevices where edges are joined to top deck. These crevices form natural traps for food and dirt particles. Usually, adhesions can be loosened only by scraping with a knife or other sharp instrument. Even then, deposits can't be completely removed. It is impossible to achieve real cleanliness. Extra time and labor are required every time the conveyor is cleaned.

Blickman's new seamless top construction, however, permits thorough sanitation. Round and rectangular wells are *actually part of the top deck*. Where edges of the wells meet the top, they form *smooth, continuous, crevice-free surfaces*. There are no recesses where dirt can lodge. Cleaning is quick and easy. Just wiping with a damp cloth keeps the highly-polished stainless steel surfaces bright, clean-looking, sanitary!



SEND FOR *New* VALUABLE BOOK

Describing complete line of Blickman-Built food conveyors, including the widely-acclaimed selective-menu models. Contains detailed specifications.



BLICKMAN SANITARY TOP
showing smooth, continuous surfaces where wells meet top deck. Cleaning is simple and quick. There are no crevices where dirt can lodge.

Blickman-Built food conveyors alone offer the seamless, sanitary top as standard construction. Investigate this—and other essential features, before you buy your next food conveyor.

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One conveyor now gives you a great variety of inset arrangements for your selective menus. Interchangeable square and rectangular pans can be placed in the rectangular wells in different combinations. Round wells are used for soup or other liquids; two heated drawers for special diets. There are many other interesting features—write for complete information.



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FOOD SERVICE EQUIPMENT



COFFEE URNS



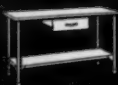
STEAM TABLES



FOOD CONVEYORS



SINKS



WORK TABLES

spoons lemon juice; 5 medium sized eggs (1 cup); 2 cups cake flour; 1 teaspoon salt. *Method:* Cream fat and sugar together for 10 minutes. Beat in lemon rind and juice. Add eggs one at a time, beating 1½ minutes after each addition. Add the flour sifted with salt all at once. Beat one minute. Turn batter into greased and floured loaf pan (9 by 5 inches). Bake in a 300° oven 75 to 90 minutes.

Chocolate frosting: Mix 2 cups confectioner's sugar; 4 tablespoons table fat and enough cream to spread well. Add 2 ounces of melted chocolate.

Vegetable Buying

For a start toward buying according to measure, keep a table of figures on the number of servings offered by a pound of various foods as purchased to refer to when planning meals and writing market lists, says the U.S. Department of Agriculture.

Half a cup makes an average serving of almost any vegetable. Servings from a pound of a fresh vegetable may range all the way from 2 to 8 half-cups, because of pods or other waste and because some foods shrink more in cooking.

Below are listed the number of servings ordinarily obtained from one pound of some familiar fresh vegetables in the pod, husk or other forms as purchased. Except for asparagus spears and broccoli, a serving in this table is a half-cup.

One pound:	Servings:
Asparagus, cut	4
Asparagus, spears (4 to 5 stalks per serving) ..	4
Beans, lima	2
Beans, snap	6
Beets, diced	4
Broccoli (2 stalks per serving)	3-4
Brussel sprouts	5-6
Cabbage, raw, shredded ..	7-8
Cabbage, cooked	4-5
Carrots, raw, shredded ..	8
Carrots, cooked	5
Cauliflower	3
Celery, cooked	3-4
Collards	2
Corn, cut	2
Eggplant	4
Onions, cooked	4
Parsnips	4
Peas	2
Potatoes	4-5
Spinach	3-4
Squash	2-3
Sweet potatoes	3-4
Turnips	4

This table of servings and pounds for fresh vegetables is included, with tables for other foods, in the bureau's booklet, "Nutrition Up-to-Date, Up to You," which may be obtained from the Superintendent of Documents, Washington 25, D.C., for 10 cents.

Cleaning Kitchen Fans

An electric wall fan for ventilating the kitchen needs regular cleaning to prevent a heavy accumulation of grease and dirt on the blades and on the outside opening that eventually will impair its efficiency, home economists of the U.S. Department of Agriculture say. These fans carry off steam and cooking odors and also volatile greases and black carbon. As the volatile greases come in contact with the cool surface of the fan, they solidify and leave a film that catches dirt and dust.

The simplest and easiest way to remove this film is to wipe the fan and the walls surrounding it with a cloth moistened in kerosene oil. Washing with water is not recommended because water will not dissolve the grease and may get into the motor.

How to get more meat on your trays at less cost!




Dietitians find that with the high cost of meats, it is increasingly difficult to keep within their meat appropriations and still serve nourishing meat courses to their patients. Tests have shown that certain meats roasted at 300° shrink only 10% while similar cuts of meat, roasted at 450° will shrink as much as 30%. Meat roasted at accurately controlled LOW TEMPERATURE in a large capacity, heavily insulated BLODGETT Oven retains all its flavor and juices, and gives more servings to the pound. BLODGETT'S a natural for casseroles, too. One large single deck offers space for as many as 116 low-cost individual casserole dishes.



Blodgett makes ovens from its "Basic Three" design which provides the units to make 24 models.

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*So pure... So good...
So wholesome
for everyone!*



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You like it... it likes you!



Menus for August 1951

Mrs. Emma Paquin

Dietitian
Horton Hospital
Montpelier, Vt.

1 Stewed Rhubarb Poached Egg, Toast • Pineapple Juice Baked Virginia Ham Mustard Sauce Escalloped Potatoes Kernel Corn Ice Cream • Tomato Bouillon Wheat Crackers Ham and Egg Salad Roll Sliced Fresh Peaches	2 Cantaloupe Scrambled Egg, Muffins • Tomato Juice Roast Veal With Vegetable Gravy Curried Rice Half Pear, Currant Jelly Buttered Beets Gingerbread With Whipped Cream • Consommé Julienne Cold Cuts Potato Salad Celery Hearts White Cake, Bitter Chocolate Icing	3 Prune Juice Fried Egg, Toast • Lemonade Broiled Mackerel Parslaid Potatoes Spinach Cole Slaw Plum Cobbler • Fish Chowder Oysterettes Toasted Lettuce, Tomato Sandwich Whipped Lime Gelatin With Custard Sauce	4 Grapefruit Juice Poached Egg, Toast • Cream of Celery Soup Broiled Liver, Bacon Duchess Potatoes Escalloped Tomato, Peppers and Celery Lettuce Wedge Combination Dressing Grapenut Custard • Fruit Juice Spaghetti, Italian Sauce French Bread Green Salad, Oil- Vinegar Dressing Crackers, Preserves	5 Honeydew Melon Boiled Egg, Cornbread • Cranberry Juice Roast Turkey, Stuffing Gravy Mashed Potatoes Broccoli, Lemon Butter Celery, Radish Rosés Ice Cream • Tomato Juice Turkey à la King, Rusk Lettuce, French Dressing Fresh Fruit Cup	6 Stewed Prunes Scrambled Egg, Toast • Canned Beef Boiled Potato Whole Carrot Pickled Spiced Beets New Cabbage Lemon Snow Pudding • Beef Noodle Soup Asparagus Spears With Cheese Sauce Broiled Tomato Fresh Applesauce
7 Orange Juice Fried Egg • Scotch Barley Broth Roast Lamb, Gravy Browned Potatoes Minted Pineapple and Cherry Salad Fresh Peas Cottage Pudding With Caramel Sauce • Fruit Punch Corred Beef Hash Poached Egg Sliced Cucumber Poppy Seed Roll Light Spiced Cake	8 Banana Poached Egg, Muffins • Tomato Juice Baked Ham, Raisin Sauce Candied Sweet Potato Spinach Ice Cream • Cream of Mushroom Soup Ham, Egg Salad Sandwich on Rye Bread Cole Slaw Butterscotch Chews	9 Half Grapefruit Bacon, English Muffins • Apricot Juice Meat Loaf, Creole Gravy Mashed Potatoes Summer Squash Lettuce, French Dressing Chocolate Pudding With Whipped Cream • Chicken Rice Soup Fresh Vegetable Salad Hot Rolls Baked Coconut Custard	10 Prune Juice Omelet, Raisin Toast • Cream of Corn Soup Baked Haddock, Dressing Parslaid Potatoes Wax Beans Cucumber in Sour Cream Orange Sherbet • Tomato Juice Creamed Salmon With Chinese Noodles Mellow Salad Celery Seed Dressing Chiffon Cake	11 Orange Sections Fried Egg, Toast • Apple Juice Baked Sausage Mashed Potatoes Harvard Beets Chef's Salad Raisin Rice Pudding • Blended Fruit Juice Cold Cuts Baked Potato Tomato Salad, Mayonnaise Raspberry Gelatin, Cream	12 Cantaloupe Soft Cooked Egg • Tomato Juice Roast Beef, Gravy Duchess Potatoes Green Beans Celery, Ripe Olives Ice Cream • Chicken Gumbo Fruit Salad Bowl Cream Dressing Parker House Rolls Chocolate Cupcake
13 Grapefruit Juice Scrambled Egg, Toast • Cream of Tomato Soup Meat Pie Buttered Cauliflower Green Salad French Dressing Lemon Spoon Pudding • Cranberry Juice Chicken à la King on Biscuits Jellied Vegetable Salad Iced Dressing Ice Box Cookies	14 Kadota Figs Poached Egg on Toast • Spiced Apple Juice Roast Pork, Gravy Mashed Potatoes Buttered Carrots Lettuce, Cottage Cheese Salad, Chutney Dressing Peach Cobbler • Tomato Juice Chow Mein, Rice, Noodles Tossed Vegetable Salad French Dressing French Bread Fruit	15 Stewed Prunes French Toast, Sirup • Cherry Juice Veal Loaf With Mushroom Sauce Creamed Potatoes Buttered Squash Cole Slaw Ice Cream • Chicken Noodle Soup Toasted Lettuce, Tomato, Bacon Sandwich Pickled Watermelon Rind Orange Layer Cake	16 Honeydew Melon Fried Egg, Toast • Pea Soup Broiled Hamburger, Gravy Escalloped Potatoes Green Beans Beet, Egg Salad Vinaigrette Dressing Blueberry Cake With Nutmeg Sauce • Fruit Punch Croquettes With Creamed Sauce, Peas Tossed Salad Fresh Sliced Peaches	17 Fresh Plums Scrambled Egg, Muffins • Clam Broth, Crackers Broiled Swordfish With Lemon Butter Mashed Potatoes Broccoli au Gratin Pepper, Red Onion Rings on Lettuce Brown Betty • Corn Chowder Tuna Fish Salad Roll Stuffed Olives Coffee Soufflé	18 Banana Poached Egg on Toast • Fruit Juice Beef Stew With Baking Powder Biscuit Pickled Spiced Beets Lettuce Roquefort Dressing Banana Cornflake, Cream • Consommé Cold Sliced Ham Potato Salad Carrot Sticks Hard Rolls Fresh Fruit Cup
19 Cantaloupe Bacon, Egg, Toast • Apricot Nectar Duck à la King in Patty Shell Currant Jelly Baked Paprika Potato Fresh Peas Raspberry Sherbet • Chicken Rice Soup Melba Toast Assorted Sandwiches Celery, Radish Rosés Mocha Bavarian Cream	20 Orange Juice Soft Cooked Egg • Tomato Bouillon Hamburger Roll, Gravy Creamed Potato Fresh Spinach Chef's Salad Rhubarb Pandowdy • Beef Celery Broth Wheat Crackers Fresh Fruit Salad in Melon Slice Hot Rolls Sponge Cake, Ice Cream	21 Grapefruit Sections Scrambled Egg, Toast • Pineapple Juice Roast Lamb, Capser Sauce Mashed Potatoes Buttered Diced Carrots Half Pear, Mint Jelly Creamy Rice Pudding • Fruit Juice Open Club Sandwich Sweet Mixed Pickles Washington Cream Pie	22 Applesauce Poached Egg on Toast • Green Split Pea Soup Baked Ham Candied Yams Escalloped Tomato Celery, Peppers Pineapple Cole Slaw Gingerbread With Whipped Cream • Blended Fruit Juice Ham, Noodle Casserole Green Salad Oil-Vinegar Dressing Coconut Cupcakes	23 Prune Juice Pancakes, Sirup • Lemonade Swiss Steak Browned Potatoes Cauliflower With Cheese Sauce Beet, Egg Salad Vinaigrette Dressing Fruit Gelatin • Fresh Vegetable Soup Chicken Salad Sandwich Assorted Relishes Apricot Tarts	24 Half Temple Orange Omelet, Toast • Cranberry Juice Wheat Crackers, Chives, Cheese Quahog Pie Green Salad With French Dressing Hot Devil's Food Cake, Marshmallow Topping • Cream of Asparagus Soup Egg Salad in Tomato on Watercress Baking Powder Biscuits Melon, Fresh Lime
25 Stewed Rhubarb Bacon, Egg, Toast • Mulligatawny Soup Veal Patties With Tomato Sauce Escalloped Potatoes Corn on the Cob Molded Fruit, Cottage Cheese Salad Butterscotch Pudding • Fruit Juice Creamed Dried Beef Mixed Vegetable Salad Assorted Cookies	26 Seedless Grapes Scrambled Egg, Muffins • Cherry Juice Broiled Steak French Fried Potatoes Fresh Lima Beans Carrot, Olive Salad Macaroni Ice Cream • Chicken Gumbo Soup Asparagus on Toast With Cheese Sauce Watermelon	27 Grapefruit Juice Poached Egg on Toast • Vermicelli Soup Braised Liver With Vegetables Baked Potatoes Orange, Grapefruit Salad Bread Pudding With Fig Sauce • Tomato Juice Baked Macaroni, Bacon Deviled Egg in Red Onion Ring French Dressing Lemon Meringue Pie	28 Melon Soft Cooked Egg • Consommé Princess Roast Lamb, Mint, Gravy Lyonnaise Potatoes Escalloped Potatoes Fresh Spinach Spiced Pear, Cottage Cheese Salad Lime Sherbet • Apple Juice Hamburger, Bun, Catsup Potato Chips Lettuce 1000 Island Dressing Floating Island	29 Prune Juice Scrambled Egg • Jellied Consommé, Crackers Chicken Pie Summer Squash Apricot, Cream Cheese and Nut Salad Chocolate Pudding With Whipped Cream • Beef Noodle Broth Spanish Omelet, Gravy Molded Fruit Salad Mayonnaise Spiced Cupcakes	30 Grapefruit Sections Poached Egg on Toast • Blended Fruit Juice Roast Beef, Gravy Duchess Potatoes Mashed Turnip Tossed Vegetable Salad Pineapple Upside Down Cake • Cream of Carrot Soup Assorted Sandwiches Lettuce, Tomato Salad Russian Dressing Brownies
31 Apple Juice, Soft Cooked Egg • Celery Broth, Baked Halibut, Lemon, Mashed Potato, Eggplant au Gratin, Diced Cucumber Salad, French Dressing, Ice Cream • Tomato Juice, Vegetable Pie With Cheese Biscuit Crust, Pickles, Olives, Fresh Fruit Cup, Cookies Ready-to-eat or cooked cereals are offered on all breakfast menus.					

hasten the recovery

...with
plenty of
 citrus
 fruits



References:

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2. Bruger, M.: *New York State J. Med.*, 44:2701, 1944.
3. Owens, G.: *J. Kansas M. Soc.*, 47:458, 1946. 4. Lund, C. C. et al.: *Arch. Surg.*, 55:557, 1947. 5. Collier, F. A. and DeWeese, M. S.: *J.A.M.A.*, 141:641, 1949.
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For all patients on surgical wards, to help insure maximal tissue repair and wound healing,^{1,2,3} sound supporting therapy today usually calls for the routine administration of adequate vitamin C,⁴ both pre- and post-operatively. The nutritional preparation of the patient is "best carried out by the normal oral route whenever possible."⁵ Fortunately, most everyone likes the pleasing flavor of Florida citrus fruits, so rich in vitamin C, and contributing other nutrients.* Whether fresh, canned or frozen, it is possible—under modern techniques of processing and storage—for citrus fruits and juices to retain their ascorbic acid content, and their flavor appeal, in very high degree over long periods.^{6,7} Their energizing influence, because of their easily assimilable fruit sugars,⁸ also gives constructive assistance in hospital care.

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*Citrus fruits—among the richest known sources of vitamin C—also contain vitamins A and B, readily assimilable natural fruit sugars, and other factors, such as iron, calcium, citrates and citric acid.



GARMENT CONVEYOR

*irons out the "wrinkles" in
the laundry equipment*

JACK W. RIVALL

Administrative Resident
St. Luke's Hospital
Duluth, Minn.

SEVERAL problems in the new laundry (constructed to service 500 beds and 55 bassinets) of St. Luke's Hospital, Duluth, Minn., have been neatly solved by the installation of a newly designed, power-driven garment conveyor. Congested work space for the presses, excess traffic throughout the plant, and unduly wrinkled finished products have been entirely eliminated, while an improved service is given to personnel who have uniforms laundered in our plant.

In 1948, when our recently completed building program was still in

the planning stages, much consideration was given to two problems. The first involved the development of a smooth flow of traffic through the entire laundering process.

The plan was to channel the soiled linens up the north side of the laundry for washing and drying, and back down the south side through the presses or ironers to the linen room. As can be seen by the floor plan showing the flow of work, the laundry moves smoothly through the washers, extractors and the shake-out tumbler, but from this point the lines of traffic become more complicated. The work can go from here to any one of five places: the rough work driers, the blanket drier, the two flatwork ironers, or the presses. The finished goods must then be taken to the linen room. As indicated by the arrows in the diagram, traffic in the east end of the laundry tends toward congestion, and any relief would be most desirable.

The second problem was the realization that the area which could be allowed to the presses might become crowded. Three hand ironing boards, three garment presses, six mushroom presses, and a double sleeve are needed to handle the work load, and this would leave little room for the storing of the finished garments. As can be seen on the floor plan, any expansion of the area to the north was limited by the center aisle, which had to be kept clear as it leads to a fire exit. Westward expansion was stymied by the six-roll flatwork ironer.

An answer to both of these problems was found in one of our local dry-cleaning establishments. It was a simple, inexpensive, power-driven, moving garment conveyor system de-

KEY TO LAUNDRY PLAN

1. Scale
2. Starch cooker—50 gallons
3. Washer—42 by 54 inches
4. Washer—42 by 84 inches
5. 100 gallon soap tank
6. Washer—42 by 36 inches
7. Extractor—30 inches
8. 100 gallon soap tank
9. Extractor—54 inches
10. Overhead monorail
11. Tumbler—72 inches (shake out)
12. Tumblers—36 by 30 inches (rough work driers)
13. Two-compartment dry room (blanket drier)
14. Press units (mushroom)
15. Press units (garment)
16. Damp box
17. Remo reel
18. Ironing boards
19. Shakeout table on casters 4 by 7 feet
20. Feed bars
21. 120 inch—6 roll ironer
22. 3 by 10 foot table
23. 120 inch—8 roll ironer with automatic folder
24. Stacking table 3 by 10 feet
25. Controller
26. Canopy
27. Three-compartment laundry tray
28. Filing cabinet
29. Chair—straight without arms
30. Desk lamp (fluorescent)
31. Desk 50 by 34 inches
32. Office chair
33. Wastepaper receptacle
34. Soiled linen bins
35. Laundry chute
36. Folding tables
37. Double sleeve

In hospitals

Westinghouse MICARTA

is the plastic surface that
serves better - more ways



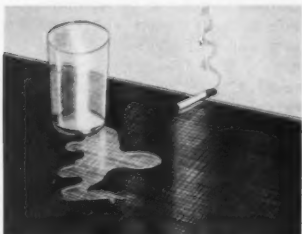
Super-sanitary, and unharmed even by caustic cleaners. Non-porous Micarta permits absolute sanitation because nothing can penetrate it and the simplest, easiest, fastest wiping will clean it completely.



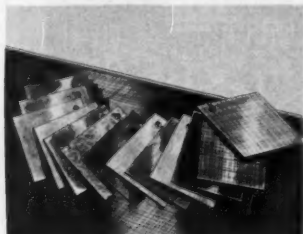
Resists strongest staining agents. Alcohol, bleaches, chlorides, dilute acids—even iodine—won't stain or attack Micarta. On bedside furniture, medicine tables, kitchens, laboratories it takes the roughest abuse—never stained, never harmed.



Takes toughest wear—never dented or cracked. In kitchens, floor service centers, dining rooms, cafeterias, Micarta tops stand up under heavy use. Even banging pots won't mar this super-tough plastic.



Handsome, stainproof, cigarette-proof furniture tops. Imagine fine bedroom furniture with tops neither nurses, orderlies nor visitors can harm—in any way. That's the magic of Micarta. And by using Micarta Truwood your furniture is naturally beautiful. Micarta Truwoods are real wood veneers encased in imperishable plastic so that they look exactly like the wood sides because they are matching woods.



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veloped by the Dahlberg Machinery Company of Duluth.

The principle feature of the conveyor is an ordinary $\frac{3}{4}$ inch steel tube around which a heavy, specially made coil is wound; the general overlying idea being that as the tube turns, the coil pushes the garment hanger along the tube in the same manner that a nut moves along the thread of a turning bolt. Adjustments in the motor are provided to control the speed of travel of the garments, and a special curve arrangement, incorporating a unique and proven torque unit, pro-

vides for the transfer of both the power and the garments around curves up to 90 degrees and also provides for raising or lowering garments from one level to another with inclines and declines up to 25 degrees.

With the installation of this device, the two previously described problems were alleviated. All cart pushing or manual carrying of garments to and from the presses and the linen room has been eliminated, while the necessity for having storage racks taking up precious space in the pressing area has been completely done away with.

Several other advantages have been derived by the use of a power-driven garment conveyor. The service to personnel having uniforms laundered in our laundry has been improved in two ways. The continuous removal of uniforms on an automatic basis prevents the crushing and wrinkling that is likely to appear when garments are bunched in one place. Also, when a uniform has been pressed, in a matter of minutes it is in the linen room ready for distribution to the employee, thereby giving him a better pick-up service by several hours.

A rather intangible advantage in not having storage racks in the press area is that the workers cannot compare their outputs. This defeats any thoughts of one press operator's slowing down because she has done more uniforms than another, and generally improves worker morale.

Another asset is that garment inspection becomes a simpler but more thorough job as each uniform comes into the linen room individually. This enables a much more exacting inspection than could be had by pushing through a crowded clothes rack. We are presently exploring the possibilities of greater utilization of our conveyor by such means as baskets with hooks to carry folded articles to the linen room.

One of the most appealing aspects of our garment conveyor is the overall cost picture. The installation price is relatively inexpensive for a power-driven conveyor. The device is powered by a $\frac{1}{4}$ h.p. motor hooked into the regular lighting circuit of the plant, making operating costs only slightly more than one would expect to pay for a continuously burning electric light. In six months of operation we have not encountered any maintenance expense, and it appears that future expenses will be nominal as the slow revolving motor affords minimal wear and tear on moving parts.

In conclusion I should like to list briefly the advantages we have found in the use of a garment conveyor:

1. Plant traffic is considerably reduced.
2. The finished uniforms are less wrinkled.
3. Inspection of the finished work is simpler and more thorough.
4. A better pick-up service is offered personnel having uniforms laundered.
5. A less congested press area allows more work to be done in the same amount of space.



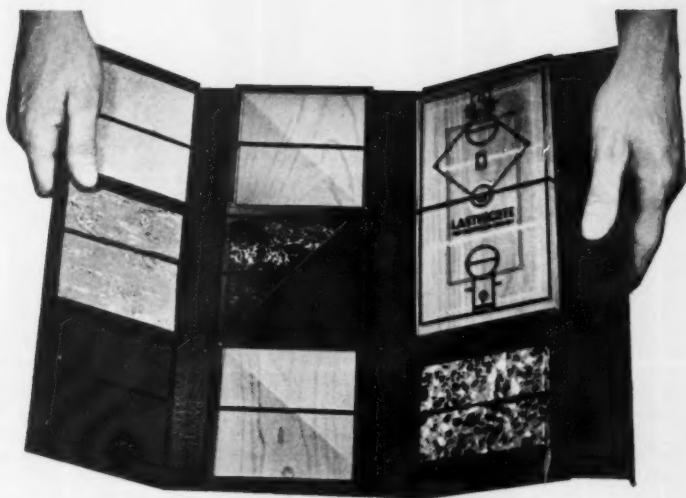
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The housekeeper can't divorce herself from

GOOD FOOD SERVICE

NOT too many years have passed since housekeeping and dietary departments were one and the same; either the housekeeper was in charge of food or the dietitian was in charge of housekeeping. But with the extraordinary growth of hospitals and the added demands for special diets and balanced menus the dietary department became so specialized that the dietitian had no time for the duties of executive housekeeper in her daily schedule. This same holds true for the housekeeper. As hospitals expanded and the need for cleaner, more attractive buildings, special floor and wall coverings and other furnishings became increasingly evident, this, too, became a specialized department. The executive housekeeper became much too involved with housekeeping problems to concern herself with the food service.

COOPERATING WITH DIETITIAN

It is not unusual today for the dietary department to employ its own porters for the purpose of maintaining the floors, furniture and equipment, with the housekeeping department doing the maintenance work on windows, venetian blinds, window screens, shades, wall coverings and covered floors. By covered floors, I mean any floor that is covered with linoleum, rubber tile or asphalt tile, inasmuch as each of these materials demands special treatment.

The executive housekeeper must cooperate with the dietary department in many ways. One is to suggest new and more effective cleaning materials and equipment. Of course, in many hospitals, the housekeeping department still furnishes porters or housemen who do all the cleaning of floors in the

service pantries and dining rooms, and often the care of the main kitchen falls to this department. There are a few hospitals in which the housekeeping department is expected to send maids to the floor pantries to serve trays and wash the dishes. To my way of thinking, this is definitely not a housekeeping function and a housekeeping maid should not serve trays or have any part of the food service.

Clean linen is a major factor in the service of good food. Certainly, a clean tray cloth and napkin, where linen is still used, and clean tea towels are highly important. The distribution of these linens is done under the supervision of the executive housekeeper. Uniforms for the dietary department are another obligation of the housekeeping department. We are responsible for the issuing, maintenance and repair of all uniforms. In some hospitals, the housekeeper does not issue uniforms, but when the sewing room is under her supervision, they are kept in repair in this department. This is a serious problem these days with

JUNE MALONE
Executive Housekeeper
Beth Israel Hospital, Boston

the constant turnover of employees. The sewing room is responsible for the manufacture of all aprons, chefs' caps, tea towels, pot holders, and many other dietary articles.

The housekeeping department must set up a work schedule for maids and housemen so that the cleaning of rooms and wards will not conflict with the serving of trays. There must also be a schedule for special cleaning in the dietary department. This is arranged with the dietitian in charge, whether the work involves wall washing, window cleaning or cleaning of screens and lights, inasmuch as these activities cannot be allowed to interfere with the service of food.

DISPOSAL AND DELIVERIES

It is not uncommon for the housekeeping department to be responsible for the collection and disposal of garbage, and this definitely must be done in accordance with the schedule set up for the serving of food. In many hospitals, the housekeeping department is responsible for the delivery of ice to the various units of the dietary department. Delivery of ice and collection of garbage must also be scheduled according to the elevator service for the food trucks, which have priority on this service at certain times of the day; otherwise the patients would have a legitimate complaint about "cold food" and the housekeeping department does not want to be guilty of depriving patients of hot food.

When the dietary department is called upon to serve special dinners, or when it is responsible for special functions, the housekeeping department cooperates by helping to set up extra tables and chairs, and by seeing





17" absorbent name-towel



22 x 44 heavy terry towel



20 x 40 terry towel



Heavy terry bath mat



14 x 20 colored huck hand towel



17 x 32 satin border huck towel



Fine quality huck name towel



17 x 17 knit multi-color dish cloth



14 x 20 fine huck towel



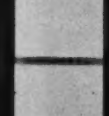
12 x 12 name-face cloth



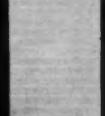
12 x 12 color border face cloth



16" huck name towel



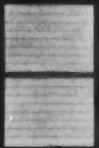
16" twill name towel



17" satin stripe huck scarfing



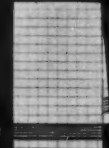
16" striped glass toweling



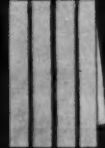
16" name glass toweling



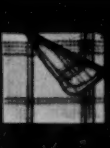
17" striped crash toweling



16 x 32 check dish towel



17 x 32 multi-color dish towel



15 x 17 waffle weave dish cloth



Double-loop silky name towel



Multi-color pot holder



Jacquard napkin (pattern)



Jacquard napkin (pattern)



17 1/2 x 19 1/2 corded border napkin



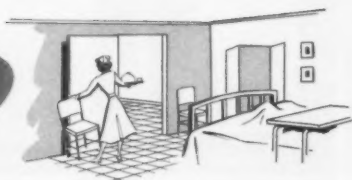
Specially constructed huck towel for face and hands.
Your hospital name woven in. Style 898.

SEE ANYTHING YOU NEED?

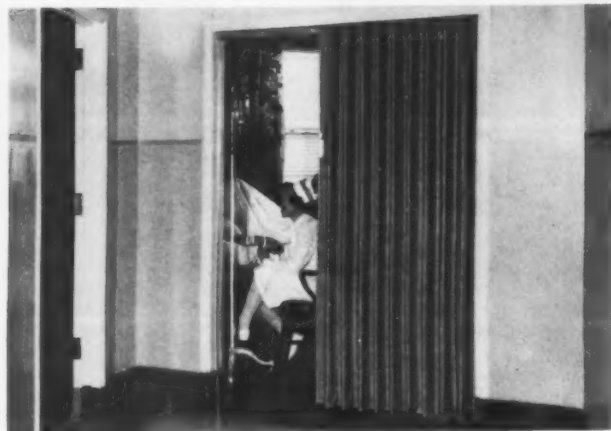
Here you see but part of the broadest single line in hospital textiles—Cannon's! Many of these items were designed by special request. All Cannon textiles have become the accepted standard of the industry. Whatever you need—the Cannon name is your guarantee of quality. Feel free to discuss your particular problems with your distributor. Or write Cannon Mills, Inc., 70 Worth St., New York City 13.



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... Swinging Door Always in the Way



NOW...

"MODERNFOLD" DOOR Speeds Nurse's Routine!

The large swinging door made it difficult for the busy nurse to get to the bedside . . . or reach furniture and equipment in the corner. A "Modernfold" door changed all that! Its accordion-like action freed all the space around it . . . made everything easily accessible.

Many Places Where "Modernfold" Doors Aid Hospitals

Large "Modernfold" doors can be used as movable walls to make better use of hospital space. For example, a staff lounge can be divided into conference rooms whenever they're needed. Use "Modernfold" doors to separate doctors' offices from treatment rooms, in nurses' homes and internes' quarters.

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"Modernfold" doors add to the appearance of a room. The handsome vinyl covering comes in colors to blend with any decorative scheme. Flame-resistant, the covering will not fade, crack or peel. It's easily washed with soap and water. The durable covering conceals a frame of lifetime steel. Maintenance costs are practically nothing.

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Gentlemen:

Please send me full details on "Modernfold" doors.

Name

Address

City County State

that sufficient coat racks and hangers are available.

The offices of the dietary department are cleaned by the housekeeping maids and housemen, and we are responsible for making any necessary repairs. When additional tables and desks are required, we must see that these are delivered.

Last year when the dietary department of Beth Israel Hospital, Boston, moved into its new quarters, the housekeeping department played an active part in setting up this department. In fact, dinner was served in the old dining rooms on Saturday evening and Sunday breakfast was served in the new cafeteria, so it is apparent that there had to be cooperation between the two departments in order to achieve this objective.

MAINTAINS INTERNS' QUARTERS

When the hospital provides living quarters for dietetic interns, the maintenance of the home comes under the supervision of the housekeeping department of the hospital. Maid service is given and linens are issued by the executive housekeeper. She must see that all repairs are made in the house, that curtains are changed, and that once a year, at the end of the term, the home is thoroughly cleaned and the required painting and floor refinishing are done.

Sometime during the year I spend one hour with the dietetic interns, explaining procedures, methods and cleaning materials used in the housekeeping department, also why certain materials bring better results on different types of equipment and furnishings. This hour seems to give them a much better understanding of housekeeping problems. If their time would permit I believe an added hour during the year would be still more effective in helping them with the housekeeping problems they are likely to encounter when they become dietitians.

At Beth Israel Hospital, we have plans to set up a work laboratory for the purpose of group teaching and training of new housekeeping employees; this will also be used for refresher courses for old employees. If and when this has been accomplished, it is our plan to include the dietary porters in these classes, so that they, too, will have a better understanding of the proper methods of maintaining different types of floors and the correct materials to use for this work.

The MODERN HOSPITAL



Don't look now — But there's a *Shadow* on your floor

Does it come as a shock that your floor is showing its age prematurely? Are you inclined to attribute it to heavy traffic?

More probably, the excessive wear is the result of improper maintenance methods. Prove it to yourself by studying the routine of your cleaning crews.

First they wax—then they strip—then they re-wax. Not only does this subject your floor to gruelling punishment, but it is sheer waste of labor and material.

The Legge System of Safety Floor Maintenance commences with the *reconditioning* of your floor—and follows with a regular program of light upkeep. Legge service is custom-tailored to your needs. We do not operate on the principle of merely selling you a product in a can. Legge Safety Engineers examine your floors, study the composition, condition and traffic burden before recommending the *correct*

safety cleaners and polishes. Then they go a step further—instructing and supervising your crews in the efficient use of these materials.

Thousands of plants, buildings and institutions rely on the Legge System to keep their floors in tip-top condition. It costs nothing to get complete data about our service. Simply clip the coupon to your letterhead and mail today for a revealing booklet on scientific floor care. It's free and puts you under no obligation. Will you mail it now, please?

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Please send me a free, no-obligation copy of your Mr. Higby book.

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Title _____

Types of flooring _____

Area _____ sq. ft.

H-7



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TRUDEAU AND KOCH

(Continued from Page 91)

The homely little thermostat served his purpose well enough. Heated by wood during the day, it retained some heat at night because he had encased it in four wooden boxes stuffed between with wool and shavings. It was this crude thermostat that caused the

fire in later years that destroyed his home and laboratory. The water supply in his laboratory at first consisted of an overhanging pail which drained into a pail beneath the bench. With this simple setup he was able to reproduce Koch's bacillus and prepare its

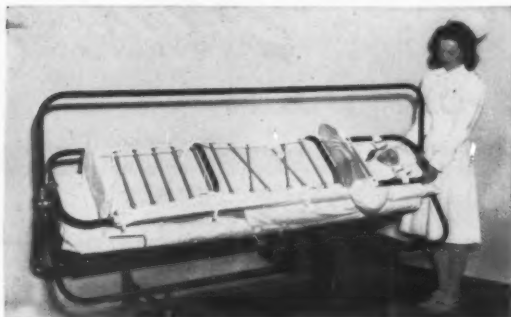
culture. Soon Trudeau was diagnosing tuberculous cases by examination of sputum. Like Koch, he attempted to prepare a vaccine for tuberculosis and, like Koch, he failed. When Koch sent him some of his precious tuberculin, he tried in vain to produce a cure for, unknown to him, it was much the same product he had been preparing in his own homespun laboratory.

Trudeau's education was very limited and without scientific training, but he had all the eager interest and determination of a trained scientist and to this was joined an intense ambition to help the victims of his own great enemy, tuberculosis. It was never conquered in himself, for it was too far advanced for cure, but he found that rest, fresh air and good food brought remission. He was rarely able to obtain the necessary rest, however, for the demands for his services by the desperately ill were too great. Since tuberculin had failed to cure his patients, he turned back to his old methods. It was a great struggle in his frail health to travel the 14 miles daily to his sanatorium and back to care for the tuberculous who were gradually finding their way to his haven.

Stryker

TURNING FRAMES

In immobilization, the smallest nurse can turn the largest patient with utmost ease and safety.



A new development in the treatment of immobilized patients, the Stryker Turning Frame is essential equipment for the modern hospital. While held gently but firmly between the two frames of this unique device, any patient can be quickly turned by one nurse. One frame is removed after turning, and the other, covered with taut canvas and pad, provides a smooth, comfortable resting surface. Lying on the anterior frame, the patient can read, write and feed himself with ease. In cases of pelvic, intertrochanteric or cervical fractures, either end of the frame can be elevated to provide continuous traction throughout the turning process. Built of the finest materials, and widely accepted by orthopedists, gynecologists and neuro-surgeons, the Stryker frame saves valuable nursing time and increases the comfort and well-being of the patient.

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ORTHOPEDIC FRAME COMPANY KALAMAZOO MICHIGAN

TRAGEDIES IN HOME

Sickness and death in the family added their sorrow to his load. His first-born, his adored Chatte, had grown up strong and vigorous in that cold climate, but fell sick when she went away to school. Telling her to come home, Trudeau with horror saw the familiar signs in her and a laboratory test confirmed his suspicions. He had to watch her slowly die. He had seen so many of the hopelessly ill and these he refused to admit to the sanatorium but it hurt him greatly and he visited them and provided what comfort he was able. Crowds of patients filled his office demanding to see none but Trudeau, although he had obtained excellent physicians to assist him.

In 1893 when his house burned down with his laboratory, while he was on a visit to New York, he was overwhelmed. He was deeply touched when the men from the laboratory where he had learned the preparation of slides presented him with a new microscope and a friend built him a new and better laboratory. He always wondered why so many were so good to him. When in 1910 the sanatorium cele-

Are you planning to build a brand-new old-fashioned hospital?



AFTER much debate, the gentlemen above are voting *not* to install individual room temperature control in their new hospital—as an “economy” measure.

But is it economical to plan a new hospital that may be old-fashioned before it's completed?

That's the possibility these gentlemen face. As most hospital administrators know — it is becoming more and more routine in medical practice to give each patient the exact room temperature he needs to accelerate his recovery—whether it's 65° or 85°. And this “prescription” can be filled *only* with individual room temperature controls. No other system can maintain different temperatures in different rooms. No other system can compensate for the varying effects of wind, sun, open windows and number of room occupants.

Since that is true, it's just smart business to install individual room temperature controls *when your hospital is being built*. Doing it later, as a modernization project, is sure to cost substantially more money.

So why not get the complete facts and figures on Honeywell Controls for your new hospital? Honeywell—first in controls—offers many important features you'll want, including the only thermostat specially designed for a hospital's special needs. Call your local Honeywell office. Or mail the coupon today!

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Honeywell

First in Controls



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Minneapolis 8, Minnesota, Dept. MH-7-115

Gentlemen:

Please send me literature and full details on individual room temperature control for hospitals.

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Hospital Name _____ Address _____

City _____ Zone _____ State _____

brated its twenty-fifth anniversary, 117,000 patients had passed through its doors. Two years later, to the staff of fine physicians was added a training school for nurses, many of whom had been cured of the disease and had caught Trudeau's vision. The doctor's health was now gradually failing and the loving guides cut paths through the hunting grounds so that he could continue hunting, shooting from the rocking-chair they carried on long poles.

Trudeau was 67 when he died in 1915. His brilliant young son Ned

had just begun his medical career in 1900 when he died of pneumonia and almost broke his father's heart. Fortunately another son, Dr. Francis Trudeau, lived to carry on the great work.

No comparison can be made between Trudeau and Koch—between their work or between the men themselves. Each was a contributor to scientific medicine, each served mankind. Koch, a great scientist, made a great contribution to bacteriologic and laboratory methods. Many epidemic diseases were brought under control through his research. He gained world-

wide renown. Trudeau, the frail invalid, warring against tuberculosis in himself, fought with all his strength against the disease in others who sought his help. He brought hope of recovery to thousands who like himself had been condemned to die, and to countless others he had made the passing easy. Following his pioneer work, hundreds of sanatoriums devoted to the care of the tuberculous sprang up across the United States and gradually tuberculosis lost its prime importance as a killer; today it is seventh on the list of fatal diseases.

In his "autobiography" Trudeau unconsciously wrote his own eulogy. He said: "Spiritual courage is of higher type than physical courage. . . . It takes a higher type of courage to fight bravely a losing than a winning fight, especially if the struggle from the first is evidently a hopeless one and is protracted for years. . . . The victories the world acclaims and rewards are the victories of success and achievement and triumph over the material forces of the universe, but the victories of the spirit, the victories of the vanquished, it takes little heed of. And yet the record of the ages shows that such victories that require the highest type of courage have been as enduring as any material achievements and still speak their great message to the higher life of man, with a clearness which neither time nor the acclaim of the successful conquerors in life can dim."

Trudeau lived to be acclaimed for his great work and lived to see the National Tuberculosis Association established, serving as its first president, and furthermore lived to see the great Trudeau Foundation endowed. His was the spiritual courage that leads to great achievements.

one of the



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- 7 LAUNDRY AND CHUTES
- 8 PAINT
- 9 UTILITY ROOMS

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The most in economy
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Englander-Airfoam* gives you the most of all three!

That's a big order for any mattress to fill! But Englander means it, and the facts are all here to prove it.

Englander and Goodyear have combined to produce this modern miracle mattress. It had to be better than any mattress in every way. Here's the result.

The most in comfort. On Airfoam your patient actually sleeps on air. Millions of tiny air cells throughout the mattress cradle the patient and suspend him on a soothing, billowy puff. Restlessness is minimized because the air cells expand and contract, as only air can, with every movement of the body. Comforting, soothing support is always there, from head to toe. And the Airfoam Mattress can't lump or sag. The surface gives evenly all over.

The most in economy. On the basis of service and long life, Airfoam is the cheapest mattress you can buy . . . far cheaper than any innerspring mattress at a comparable price. It is of one-piece construction, with no springs. Tests equivalent to ten years of abuse have failed to break down Airfoam. Timesaving, too, because the Airfoam Mattress never needs turning, and is so feather-light that it can be made in a jiffy. The corners lift for sheet and blanket tucking with finger-tip pressure.

The most in cleanliness. Unlike ordinary mattresses, the Airfoam is allergy free, completely dustless, bacteriostatic, mildew-proof, cool and odorless. For further sanitation the cover is 8-oz. government standard, sanforized ACA, with rustproof zipper. It slips off in seconds for laundering. For hospital cleanliness it cannot be compared with any other mattress.

**There's more to the story.
Get it from any hospital supply dealer.**

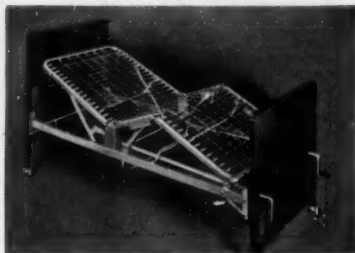
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Modern, de luxe bed and spring ensemble



THE BED . . . Englander's newest hospital bed leads the trend toward simple, classical design. Its handsome panel styling will give a modern touch to any hospital room. Its smooth, baked enamel finish is as lasting as it is beautiful, and so easy to clean. It is available with standard or heavy-duty Gatch Spring, or with two-crank Trendelenberg Spring illustrated.

THE SPRINGS . . . the two-crank Trendelenberg Spring is of the same rugged construction as the standard Gatch Spring. It affords the additional positions of: Trendelenberg, reverse Trendelenberg and hyperextension. All of these positions are accomplished by the simple manipulation of the two telescoping cranks. The operative mechanism affords noiseless and effortless adjustments.

A.M.A. APPROVES JOINT ACCREDITATION

(Continued From Page 52)

further decisions on accreditation were left with the board.

At its final meeting following settlement of the standardization problem, the house named Dr. Louis H. Bauer of Hempstead, N.Y., president-elect of the association. Dr. Bauer, who has served as chairman of the board of trustees for the last several years, will succeed Dr. John W. Cline

of San Francisco, who became president during the session, following Dr. Henderson.

In his presidential address Dr. Cline emphasized progress in medical education and indirectly answered critics who have warned of a coming doctor shortage. "There are more students preparing for careers in medicine than at any other time in our history," he

declared, "and by 1960 we will be producing at least 30 per cent more physicians than we did in 1950. This tremendous growth will be accomplished without sacrifice in the quality of education. To fail to maintain our present high standards would be ruinous to the future of medical care."

Dr. Cline acknowledged that some medical schools were in financial difficulty but pointed to the newly organized medical education foundation as the right way out. "In addition, we advocate one-time federal grants for necessary construction and remodeling of medical school plants," he stated, referring to an action taken by the house of delegates during this session. "The association believes that medical education can be financed adequately by these means without the danger of federal control."

TRIBUTE TO WHITAKER, BAXTER

Some 12,000 strong, the nation's doctors looked prosperous and contented as they paced the boardwalk and the exhibition hall and attended their many scientific sessions and organization meetings. The general well-being of the profession was given frequent and pointed mention by association officers who sought and easily obtained approval for their conduct of the association's battle against socialized medicine. Announcing continuation of the association's National Education Campaign for another year, retiring president Henderson paid fervent tribute to Whitaker and Baxter, the public relations counsel who directed the campaign. Delegates enthusiastically endorsed this approval, unquestionably reflecting the prevailing opinion throughout the medical profession, though there were a few who observed that the A.M.A. and Whitaker and Baxter also owed a vote of thanks to the North Korean Army for a diversionary action which had helped turn aside the threat.

Mellowed by its political success, the A.M.A. was ready to take the public in as a partner in the business. Delegates approved a trustee recommendation for the establishment of a committee of prominent laymen representing industry, labor, agriculture, education, the bar and the clergy to advise the association in matters of medical care and to present the point of view of the general public. Members of the committee would not be appointed for several weeks, an association announcement said, but they

When^{*} is a nurse a happy nurse?



*
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- * Non-tearing neck
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MANY a hospital accounting department is on the critical list. Because it can't provide evidence of actual costs for services rendered, it must limp along on skimpy revenues from "third party" agencies.

To make ends meet, hospitals *must* obtain equitable payment rates from public and private welfare, benefit and insurance agencies.

The "third party" agencies want solid

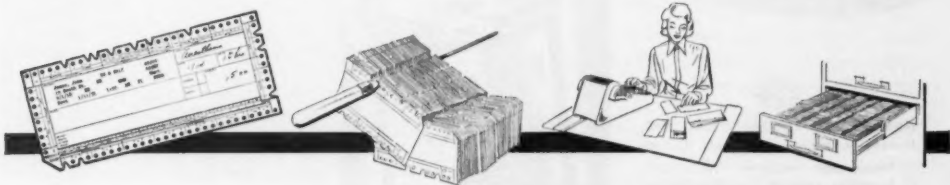
proof of costs—and that's where the McBee Keysort Charge Ticket comes in. McBee is sending these "get well" cards to scores of hospitals all over the country . . . and the hospitals are doing nicely, thank you.

With existing personnel, without costly installations, Keysort Charge Tickets and machines provide a hospital with complete cost-control information at less cost than any other method.

When notched, the pre-coded holes along the edges of each Keysort Charge Ticket make it easy to *collect* the facts on each patient . . . *classify* them . . . *file* them . . . *find* them . . . *use* them . . . quickly and accurately.

Hospitals everywhere are using Keysort evidence to recover costs and for many other administrative problems.

Ask the McBee representative near you for full details. Or write us.



THE McBEE COMPANY

Sole Manufacturer of Keysort—The Marginally Punched Card
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would be men and women "not engaged in politics" and "so outstanding that their opinions will automatically receive respect," it was assured.

In another action unquestionably related to its awakened political awareness, the association noted that socialization of medicine was "just one phase of a long-range plan to collectivize every phase of our economic and social structure." With this clear and present danger in mind, the house of delegates dealt itself a hand in the popular game of pointing an accusing finger at the public schools.

"Many of our educators and many of the organizations to which they belong have for many years conducted an active, aggressive campaign to indoctrinate their students in grammar school, high school and college with the insidious and destructive tenets of the welfare state," said a resolution introduced by a California delegate and promptly passed.

"This teaching of hatred and scorn for the American system of private enterprise has been so widespread and successful that as a result our voters are conditioned to accept all manner

of totalitarian expedients in direct violation of economic law." The resolution called for a congressional investigation of "such teachings by individuals and the subversive textbooks to implement such teachings."

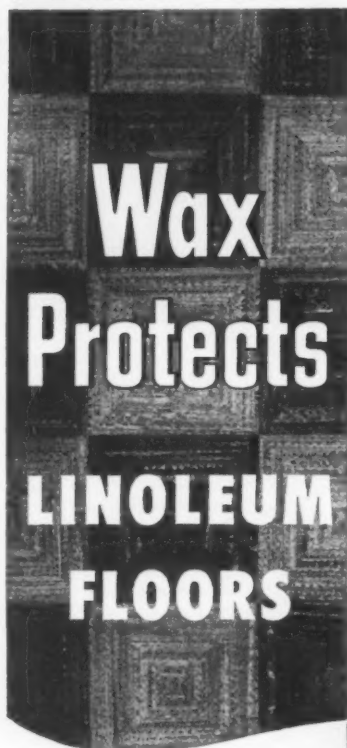
SOOTHING WORDS FROM DAVE BECK

In another free-swinging resolution, the delegates expressed their unalterable opposition to "communism, nazism, fascism, state socialism and any other form of collectivism." Those who wondered why the A.M.A. was officially concerning itself with such apparently irrelevant problems as nazism and subversive textbooks could find an answer in such convention facts as the registration of 78 writers representing 58 newspapers, wire services and magazines, and the presence on the program of Dave Beck, executive vice president of the International Brotherhood of Teamsters, A. F. of L.

Mr. Beck was opposed to socialized medicine, socialism and communism, and, on two nationwide radio networks, he had these soothing words for the doctors: "The doctor in America has won his present high place in the hearts and spirits of our people through his study, toil, sacrifice and service. . . . The opportunity to meet the challenges of disease and death has been taken by the doctors using the weapons of science, truth and skill—all wielded within the framework of a free society. You have earned the respect of your fellow countrymen over and over through the work you have done on Main Street, in our great cities, on the battlefield, in our hospitals and in the classrooms."

In one of its closing sessions, the house of delegates rejected a proposal to create a section on public relations within the scientific assembly of the A.M.A. Plainly, no such formal section was needed; the A.M.A. was handling its public relations with all the finesse of an experienced political campaigner.

As Dave Beck put it: "You doctors have a pretty good union. I believe in organization—it leads to mutual exchange of ideas, knowledge and information, and mutual protection. I believe in it for the laboring man and I believe in it for the doctor. I say to the doctor: join and support your organizations—locally and nationally—and continue the fight for high medical standards, for your own self-preservation and against this monstrous evil of socialization. More credit and glory to you!"



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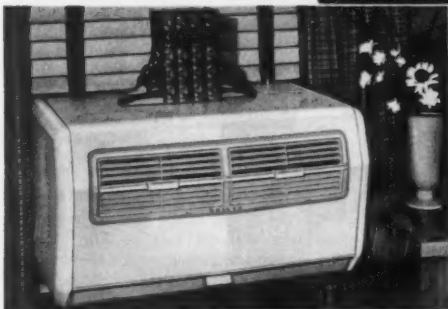
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NEWS DIGEST

Defense Questions and Federal Controls Concern Catholic and Middle Atlantic Associations . . . State Associations Name Leaders . . . Hospital Design Winners Picked . . . A.N.A. Makes Research Grants . . . A.H.A. Convention Plans Shaped

Catholic Hospital Association Told of War Responsibilities

PHILADELPHIA.—The Very Rev. Msgr. C. A. Towell, diocesan director of hospitals at Covington, Ky., was named president-elect of the Catholic Hospital Association of the United States and Canada at the association's 36th annual convention held here June 2 to 5.

Other officers elected were: first vice president, the Rev. Francis P. Lively, associate director, division of health and hospitals, diocese of Brooklyn, and second vice president, the Very Rev. Msgr.



President-Elect Msgr. Towell and new vice presidents, Father Lively and Msgr. Maher.

Robert A. Maher, diocesan director of hospitals, Toledo, Ohio. Sister Marguerite Mann, St. Boniface Hospital, St. Boniface, Manitoba, and Sister Catherine Gerard, Halifax Infirmary, Halifax, Nova Scotia, were elected to the board of directors.

General theme of the convention was "The Responsibility of the Catholic Hospital in Critical Times." The Most Rev. William A. O'Connor, D.D., episcopal chairman of the association's administrative board, declared at the opening session:

"The greatest position of the church in the field of health and hospitals is not our hospitals, but the sisterhoods and the brotherhoods who conduct the hospitals. We must be very careful not to become subordinated to the institutions we create. We use hospitals to serve the sick but we are more important than the buildings or the system—the patients are more important!"

"The rôle of the civilian hospital as a defense supporting facility is well established," Charles G. Lavin, program (Continued on Page 154)

Middle Atlantic Hospital Assembly Considers Controls, Defense, Personnel Shortages

BY WARREN G. RAINIER

Mountainside Hospital, Montclair, N.J.

ATLANTIC CITY, N.J.—A total of 1763 hospital people from New York, New Jersey and Pennsylvania, plus 660 exhibit representatives attended the third annual Middle Atlantic Hospital Assembly held here May 23 to 25, the largest attendance on record.

General assembly sessions were held each afternoon, and the three state associations met during the mornings. Convening at the same time were meetings of the Middle Atlantic Assembly of Nurse Anesthetists, New Jersey and Pennsylvania Association of Medical Record Librarians, the New Jersey, New York and Pennsylvania chapters of the American Physical Therapy Association, the New Jersey State Dietetic Association, Middle and North Atlantic districts of the American Association of Medical Social Workers, New Jersey Association of Hospital Auxiliaries, and a regional meeting of the American College of Hospital Administrators.

The assembly program was focused on current hospital problems relating to government controls, civilian defense, and the acute personnel problem.

Anthony W. Eckert, director of the Perth Amboy General Hospital, Perth Amboy N.J., was named president of the Middle Atlantic Hospital Assembly; Carl P. Wright, executive secretary of the Hospital Association of New York, vice president; John F. Worman, executive secretary of the Hospital Association of Pennsylvania, was reelected treasurer, and J. Harold Johnston, executive director of the New Jersey Hospital Association, was reelected secretary.

The first general session highlighted the acute personnel shortage in hospitals today and was devoted to practical ways of getting and keeping hospital employees. Richard W. Bunch of the U.S. Public Health Service presented the problem in his discussion of "Emergency and Its Affect on Personnel."



Robert W. Gloman of Wilkes-Barre, Pa., receives gavel from Anthony W. Eckert of Perth Amboy, N. J., retiring president.

"Getting and Keeping Competent People," one of the keys to good patient care, was discussed by Ann Saunders, personnel specialist with the American Hospital Association, on the same program. She declared that "loss of employees can be met in part by sounder personnel policies and less 'underselling' of hospital jobs."

John W. Brophy, associate professor of the New York State School of Industrial Relations, Cornell University, stressed the importance of training the new worker in order to get greater production and raise the levels of performance and ambition.

The second general session was devoted to a view of the national scene. Dr. Charles F. Wilensky, president of the American Hospital Association, reported on the work of the association during the past year. He told of the formation of the new commission composed of three members each from the American College of Surgeons and the American College of Physicians and six members each from the American Medical Association and the American Hospital Association. He also announced that the A.H.A. had raised nearly \$500,000 in pledges from the National Foundation for Infantile Paralysis, the Rockefeller Foundation and the Kellogg

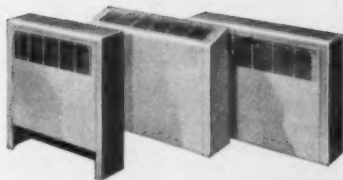
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NEWS...

Foundation for the formation of a commission to study hospital costs.

Albert Stroughton of the Washington Service Bureau of the A.H.A. outlined legislation affecting hospitals now before Congress and assured delegates that the progress of these bills is being carefully watched.

A sellers' market by fall, to continue at least for another year or so, was predicted by Charles O. Auslander, director of the Joint Purchasing Corporation, New York City, in his timely discussion of the problem of hospital supplies and equipment. He said that "if foreign conditions get worse, the defense program will be stepped up and more shortages will appear. If foreign conditions do not deteriorate," he declared, "there will not be a cut-back for some time. We are probably faced with firmer prices with price controls becoming more important."

Dr. C. Rufus Rorem, executive director of the Hospital Council of Philadelphia, told the assembly that "the survival of voluntary hospitals depends upon their ability to cooperate rather than compete with one another in service to the public. Such cooperation will keep the need for support and control by government agencies at a minimum and will enable the medical profession and hospitals to control their own destiny."

Among methods of cooperation for voluntary hospitals, Dr. Rorem listed the following: encouragement of still greater enrollment in nonprofit, comprehensive Blue Cross and medical service plans; development of closer coordination of medical service in hospitals with "institutional" aspects of hospital care; adoption of uniform accounting in hospital records; reports of service, and income and expense; group purchasing of supplies, services and equipment; community planning of capital replacement and expansion, and development of general hospitals as centers of complete medical service.

In the final general session, Dr. John B. Pastore, member of the National Security Resources Board, predicted greater shortages of physicians but warned that "we must do all in our power to keep both the civilian and military population in a state of peak fighting efficiency at all times." Dr. Marcus Kogel, commissioner of hospitals, New York City, who shared the platform with Dr. Pastore, outlined the hospitals' rôle in civilian defense.

A.H.A. Convention Plans Advance, Auxiliaries' Conference Program Set

CHICAGO.—"Trends Influencing Quality of Hospital Care" has been named as the general theme of the 53d annual convention of the American Hospital Association to be held at St. Louis, September 17 to 20, it was announced at association headquarters here last month. Major topics for discussion will include hospitals and the practice of medicine, hospital accreditation, cost, education in hospital administration, and the influence of advancing medical associations, the announcement said.

Other subjects scheduled for discussion include Blue Cross, and hospital relations and hospital needs in the mobilization program.

Some of the implications of civil defense for hospital auxiliaries, hospital costs, and a publicity clinic will be headline topics at the fourth annual meeting of the National Conference of Women's Auxiliaries to be held in conjunction with the A.H.A. convention in St. Louis, September 17 to 20.

Problems of personnel, union activity, nursing, hospital financing, civilian defense, government controls, and auxiliary aid were scrutinized at the morning sessions of the state hospital associations.

The following officers were elected by their respective state associations:

NEW YORK STATE ASSOCIATION

President, F. Wilson Keller, New York City; first vice president, Dorothy Pellenz, Syracuse; second vice president, J. Russell Clark, Brooklyn; secretary, Carl P. Wright, Syracuse, and treasurer, Moir P. Tanner, Buffalo.

Trustees: Dr. Thomas Hale Jr., Albany; Dr. Arnold Karan, Bronx; Lee B. Mailler, Cornwall; Charles M. Royle, Rochester; the Rev. Francis P. Lively, Brooklyn, and Carl P. Wright Jr., New York City.

NEW JERSEY STATE ASSOCIATION

President, W. Malcolm MacLeod, Elizabeth; president-elect, William B. Meytrott, Trenton; vice president, Robert G. Boyd, Morristown; treasurer, (vacant due to death of Howard S. Lyon), and executive director, J. Harold Johnston, Trenton.

Trustees: Dr. Edgar C. Hayhow, East Orange; John L. Brown, New Brunswick; Dr. Gerald W. Sinnott, Jersey City.

A series of group conferences will be held on Tuesday and Wednesday evenings, dealing with membership, thrift shops, patients' libraries, fairs, other projects, auxiliary problems, promotion of events, and the like. The publicity clinic, to be led by Mrs. Alice Partlow Curtis of Detroit, is the feature of the Thursday morning program; it will be followed by workshops on annual reports, radio script writing and programs, newsletters, and displays and exhibits.

Certificates for the best annual reports will be awarded on Thursday morning, after which Frank L. Weil of New York City, president of the National Jewish Welfare Board, will speak on "Apathy."

Following the pattern set at last year's successful conference, the opening morning will be given over to the state advisory counselors, and the afternoon to convention orientation of members. Tuesday morning delegates will hear officers' reports.

PENNSYLVANIA STATE ASSOCIATION

President, E. Atwood Jacobs, Reading; first vice president, Charles S. Paxson Jr., Drexel Hill; second vice president, A. H. Brittingham, Easton, and treasurer, Robert W. Gloman, Wilkes-Barre.

Trustees: J. Hamilton Cheston, Philadelphia; Sister M. Adele, Pittsburgh, and Robert L. Gill, Altoona.

Indiana Association Names New Officers

EVANSVILLE, IND.—Sister Mary Ellen of St. John's Hospital, Anderson, was elected president of the Indiana Hospital Association at its meeting May 23, 24 at French Lick, Ind. The president-elect is Edmund J. Shea, assistant administrator of Indiana University Medical Center at Bloomington.

Other officers elected include: vice president, Mrs. Fred Raison, Fayette Memorial Hospital, Connorsville; treasurer, Maude M. Woodward, Clinton County Hospital, Frankfort; executive secretary, Albert G. Hahn, Protestant Deaconess Hospital, Evansville.

The newly appointed trustees are: Mrs. Rinda F. Raines, King's Daughters' Hospital, Madison; Dr. Phillip H. Becker, James O. Parramore Hospital, Crown Point, and Crayton E. Mann, Welborn Baptist Hospital, Evansville.

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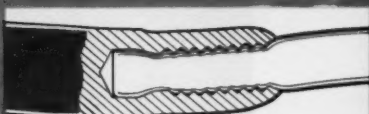
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NEWS...

Newman Heads Arkansas Association; Auxiliary Begun

HOT SPRINGS, ARK.—Kenneth Newman of Little Rock became president of the Arkansas Hospital Association at the organization's 21st annual convention held here recently.

Other officers named were: president-elect, John Rowland, Trinity Hospital, Little Rock; vice president, Sister Rita Rose, Rogers Memorial Hospital, Rogers; treasurer, George Berryman, County Hospital, Fayetteville; secretary, Eugene

Lopez, Community Methodist Hospital, Paragould; trustee, J. S. Hancock, Drew County Memorial Hospital, Monticello.

During the two-day meeting A. V. Whitehall of the Washington Service Bureau of the American Hospital Association, addressed the group on "Trends in Hospital Care."

Others who had part in the program were: Maj. Carl C. Martin, Office of Civil Defense for Arkansas; L. S. Neville, administrator of Red Cross Blood Center, Little Rock; Dr. Haydon H. Dona-

hue, Arkansas State Hospital, Little Rock; Miss M. Welch, director of the school lunchroom, Dallas, Tex.; Moody Moore, director of the division of hospitals, Arkansas State Board of Health; J. L. Redheffer, director of Arkansas Medical and Hospital Service, Little Rock; T. J. Walker, district supervisor of Bureau of Narcotics, Treasury Department, Kansas City, Mo., and Mrs. W. L. Gatz, president of the auxiliary of Community Hospital, Paragould.

The Arkansas State Nurse Anesthetist Association, the Arkansas Dietetic Association, and the Arkansas Association of Medical Record Librarians met in conjunction with the hospital association.

For the first time in the history of the association, members of the women's auxiliaries took part in the hospital program, which resulted in the formation of a state hospital auxiliary. Mrs. J. M. Flenniken of Little Rock was elected president of the group.

Connecticut Groups Agree on Nurse Personnel Policies

NEW HAVEN, CONN.—Unanimous endorsement of the revised hospital personnel policies was gained from 43 delegates from 31 hospitals when they met here at a spring assembly May 18 to act on reports and recommendations presented by the various councils and committees of the Connecticut Hospital Association.

The policies had been revised jointly by the socio-economic committee of the Connecticut State Nurses' Association and the committee on personnel policies and practices of the C.H.A.

William P. Slover, superintendent of the Manchester Memorial Hospital and chairman of the committee, presented the report.

Some of the recommendations include: a 40 hour work week and an eight-hour day, consecutive if possible, exclusive of meal time; salary ranges to be established for all hospital positions; salary adjustments to be made for employees working on evening or night duty; a physical examination to be given at time of employment, and annually thereafter, at the expense of the hospital; an exit interview to be arranged in all instances; a contributory pension plan to be endorsed in principle; opportunity to be made available for personnel to discuss problems with administration management, and promotions to be determined on the basis of merit rating.



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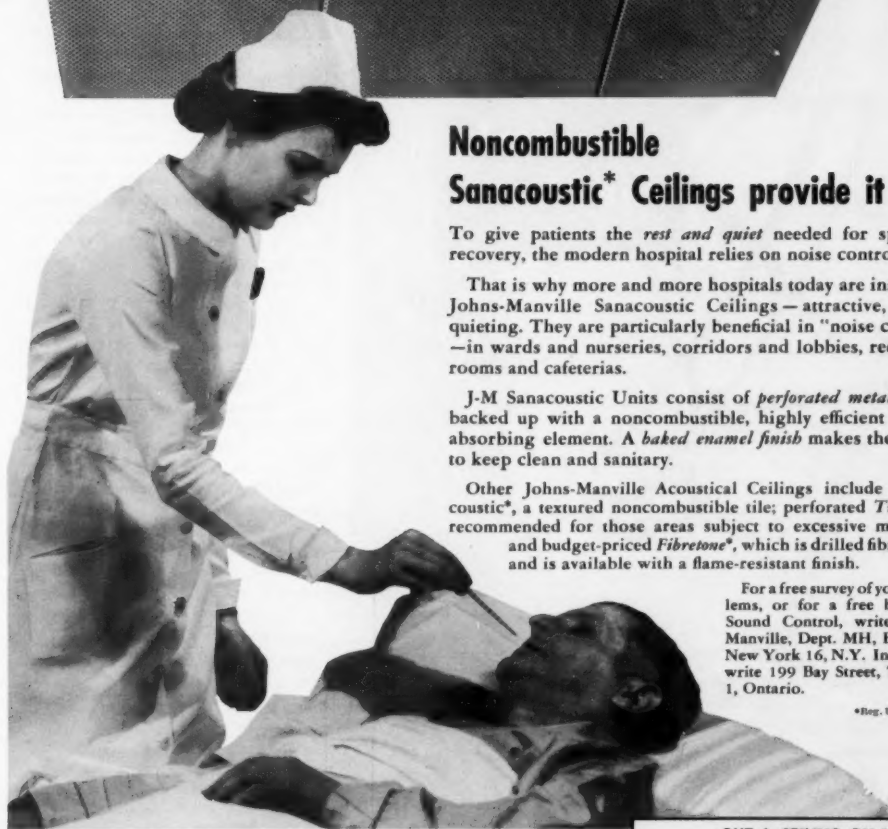
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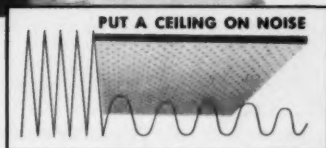
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NEWS...

Nurses Disagree With Academy Proposal

NEW YORK.—Proposals by the New York Academy of Medicine which would condense the nursing course to two years and make the third year a "nursing internship" would result in poorer patient care, Mable Detmold, president of the New York State Nurses' Association, declared here last month. The academy's proposals would "force nursing back into a form of training

that was considered adequate in 1910," at a time when the profession has heavier responsibilities than ever before in history, Mrs. Detmold said.

Offering another program instead, the association proposed opening the nursing corps of the armed services to men, reallocating hospital duties so that staff nurses would spend less time on nonprofessional duties, and raising salaries to attract more nurses into hospital jobs.

A.N.A. Announces Five Research Grants

NEW YORK.—The American Nurses' Association last month announced five grants to be made under its five-year, million dollar research program for studies of nursing functions. Ella Best, executive secretary, said the first grant is for \$10,000 to the California State Nurses' Association toward a study to determine current nursing practices of professional nurses, practical nurses, and auxiliary nursing workers.

This study, to be conducted among a group of hospitals in California, is designed to reflect conditions under every normal circumstance, Miss Best said. Results are expected to provide data for making recommendations as to proper distribution of functions among all types of nursing personnel.

A grant of \$12,860 was given to the Boston Psychopathic Hospital for the first year of a two-year study to investigate the effect on mentally ill patients of changes in patient population, normal daily events, changes in number of nursing personnel, changes in type of nursing personnel, and changes in social functioning of personnel.

Other grants approved included \$5000 for a pilot study to the New York Conference Committee for the Improvement of Patient Care; \$1756 to the Charles T. Miller Hospital in St. Paul, Minn., for a one-month activity study of all nursing personnel in the hospital; \$700 to the Rhode Island State Nurses' Association for a nursing-function study in four urban Rhode Island hospitals.

Money for this research, Miss Best stated, is being provided through voluntary contributions from professional nurses themselves.

Segregated V.A. Hospital Voted Down by House

WASHINGTON, D.C.—A bill to establish a \$5,000,000 veterans hospital for Negroes in Franklin County, Virginia, was defeated by a vote of 222 to 117 by the House of Representatives last month. Opposition was led by Representatives Adam Powell of New York and William Dawson of Illinois, who described it as "class legislation."

Representative John Rankin of Mississippi, chairman of the House veterans' committee supported the bill, contending that Negroes would get better treatment in a hospital built for them.

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NEWS...

Northwestern Graduates 45; Honors Two

EVANSTON, ILL.—Northwestern University conferred the degree of master of hospital administration upon 45 graduates and the degree of bachelor of science in hospital administration upon two on June 11.

Mortimer W. Zimmerman, personnel and public relations director of Passavant Memorial Hospital, Chicago, is the



Wayne Comer (right) presents MacEachern Award to Mortimer W. Zimmerman.

winner of the Malcolm T. MacEachern Award of \$250 and Albin H. Oberg, assistant administrator of Malden Hospital, Malden, Mass., is the recipient of



Thomas G. Murdough presents Mary H. McGaw Award to Albin H. Oberg.

the Mary H. McGaw Award of \$200, both given annually at the university.

Sponsored by the Johnson and Johnson Research Foundation, the former is given to the student who has the highest standing and who, in the judgment of the faculty, shows unusual promise of achievement.

The latter was established by Foster G. McGaw for highest scholastic standing and qualities of industry and leadership.

A.I.A. Picks Hospital Design Prizewinners

CHICAGO.—The Clearwater County Memorial Hospital at Bagley, Minn., received first award in hospital design at the 83d annual convention of the American Institute of Architects here last month.

(Continued on Page 152)



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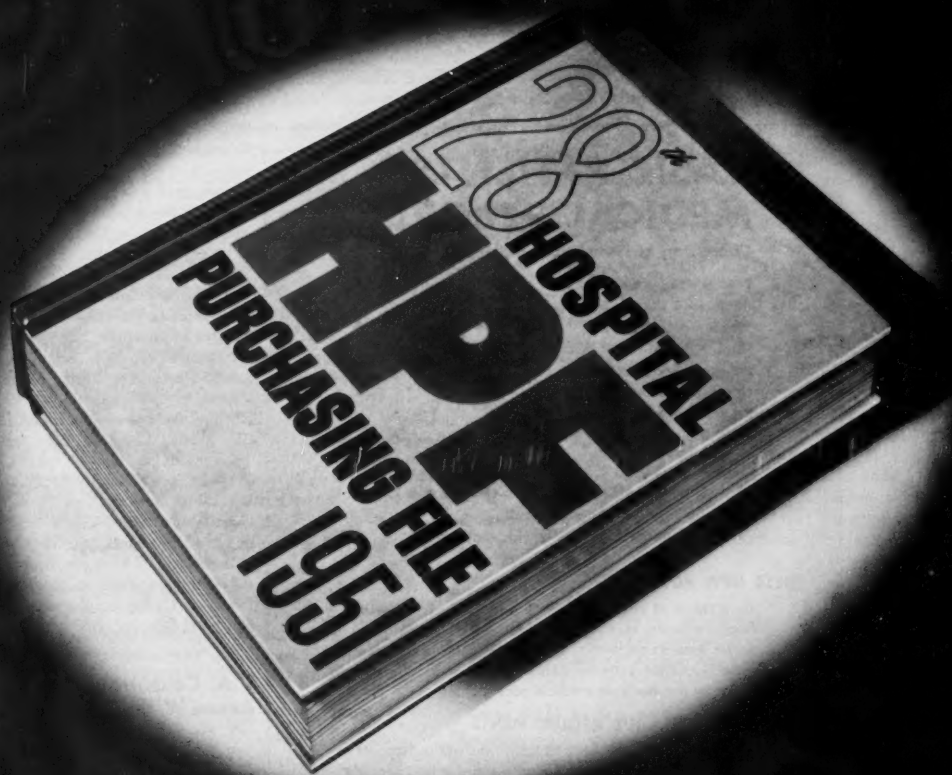
Fifty leading makers of the general professional equipment for hospitals have filed catalog data in the 28th Edition of Hospital Purchasing File which is now on your desk. . . . Here, in Section GA you will find information on ambulances, equipment for the departments of nursing and nursing education, for the operating and delivery suites (including anesthesia) and for the nursery.

Many comprehensive catalogs are included in this section, making possible careful selection and comparison. Be sure you study this section with the utmost care, encourage your department heads to familiarize themselves with the many new and improved products shown here where the most critical products used in your hospital are on display.

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NEWS...

The prizewinning hospital was designed by Edward Noakes, a member of the firm of Thorshov and Long of Minneapolis. In April the Clearwater Hospital was named "Hospital of the Month" by The MODERN HOSPITAL.

Members of the jury making the awards believed that the Clearwater Hospital solved the difficult problem of traffic in a small hospital "in an unusually satisfactory manner" through its three parallel corridors.

Other hospitals receiving awards of

merit were: Georgia Baptist Hospital, Atlanta, Stevens & Wilkinson, architects; Northern Indiana Hospital for Crippled Children, South Bend, Pohlmeier and Pohlmeier and Skidmore, Owings & Merrill, architects; Perry County Hospital, Marion, Ala., Sherlock, Smith and Adams, architects; Goodyear Memorial Pavilion (Maternity), Ventura, Calif., George B. Allison and Ulysses and Floyd Rible, architects; Xavier Hospital, Dubuque, Iowa, Schmidt, Garden & Erikson, architects.

St. Francis Cabrini Hospital, Alexandria, La., Golemon & Rolfe, architects; U.S. Veterans Hospital, Wilkes-Barre, Pa., Kelly & Gruzen and Isadore Rosenfeld, architects; U. S. Veterans Hospital, Fort Wayne, Ind., Giffels & Vallet, with A. M. Strauss, associated architects.

Connecticut Trustees Hold Third Conference

NEW HAVEN, CONN.—"Physician-Hospital Relationships" was the theme of the third Connecticut Hospital Trustees Conference at its meeting here June 29.

Sponsored jointly by the Connecticut Hospital Association and the hospital administration section of the department of public health, Yale University School of Medicine, the program consisted of the following talks:

"The Hess Report—Its History and Current Implications," Dr. Walter Phippen, chief of staff, Salem Hospital, Salem, Mass.; "The Financial and Social Impact of the Hess Report on Local Hospital Groups and on Blue Cross and Blue Shield," C. Rufus Rorem, executive director, Philadelphia Hospital Council; "Trustee Responsibility in Maintaining Workable Relationships Between the Hospital and the Medical Staff," Raymond P. Sloan, editor, The MODERN HOSPITAL; "A Realistic Evaluation of the Hospital's Role in Medical Care," Dr. Basil C. MacLean, director, Strong Memorial Hospital, Rochester, N.Y.

V.A. Consultants Agree With Magnuson

WASHINGTON, D.C.—The chief medical director of the Veterans Administration should be responsible for the medical program and operate V.A. hospitals, according to a resolution approved here last month by the national board of Veterans Administration consultants. The consultants and resolution substantially supported Dr. Paul B. Magnuson, former chief medical director of V.A., who resigned several weeks ago following a dispute with Carl R. Gray Jr., veterans' administrator over the authority of the medical director.

The dispute threatened the quality of V.A. medical service, members of the consultants group said.

Dr. Joel T. Boone, who succeeded Dr. Magnuson as medical director, told the group he had been given adequate authority to run the medical department.

BASIC PATIENTS' MEDICAL RECORD

Consisting of New Improved Forms:

Patient's Index Card

*Summary Sheet
*Record of Admission
History Sheet
Physical Examination
Laboratory Report

Progress Notes

Physician's Orders
1 and 2 sides

Graphic Chart

8-day, 4-hour, 4-8-12

Nurses Bedside Record

1 and 2 sides

Report of Consultation

Report of Operation

Report of Pathologist

X-ray Report

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Report of Accident

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(50 dup. sets to a book)

*"Summary Sheet" and "Record of Admission," forms can be used as "One-typing Sets."

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as a result of careful research and analysis, offer many improvements. Identical arrangement of headings on all forms assures uniformity and aids in finding information quickly. Color scheme helps to easily locate various forms in the patients medical record.

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Questions and Answers

about the new

Picker-Polaroid *one minute* radiograph

On March 7, 1951, before the Surgeon General and the staff of the Bethesda Naval Hospital, the Navy demonstrated the Land Process for making one-minute radiographs. The significance of this demonstration and a subsequent televised demonstration on the deck of the U.S.S. Salem was immediately sensed not only by the medical profession but by the press. To answer the hundreds of inquiries which have been pouring in as a result, we are making this report to you:

what is the process?

The one-minute, self-development principle of the Polaroid* Land Process, applied to radiography.

what does it do?

It produces a dry, finished radiograph, ready for use, one minute after the exposure is made, *without darkroom processing.*

how does it work?

- 1 You place the Polaroid x-ray packet in a special daylight-loading 10" x 12" Picker-Polaroid cassette, which fits any standard cassette tray.
- 2 Make a normal exposure in the usual way, with any x-ray machine.
- 3 Place the cassette in an automatic motor-driven processing box. Press a button...
- 4 A minute later, remove the finished print, dry and ready for use. There are no liquids present, no chemicals to handle.

what does the radiograph look like?

The image is a positive x-ray image on glossy white paper. It has excellent gradation and good density. You study it without using an illuminator.

is a darkroom needed?

No; you can load and process the radiograph in full daylight.

how will it be used?

While actual clinical experience has been limited, those who have participated during the past few years in the experimental adaptation of the process to x-ray (among them the radiological staff of the Massachusetts General Hospital in Boston) have predicted great usefulness in a variety of procedures: for fracture work, foreign body location, hip pinning and other work where speed is important. It should be useful in the many situations where darkroom facilities are not available or conveniently usable.

what will it cost?

Somewhat more than the direct cost of conventional x-ray film of similar size. When savings in processing, waiting and handling costs are considered, the actual cost difference may vanish.

when will it be available?

The entire output will go first to the Armed Services. It is hoped that by early 1952 production will have reached the point where civilian deliveries can start.

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NEWS...

(Continued From Page 140)

coordinator of the Division of Civilian Health Requirements, Public Health Service, told the convention.

"Within three years our rearmament will be well along and we should be able to marshal and equip a physical force more than equal to any combination that might conceivably be brought against us. An index of the powerful economy behind our mobilization effort is found in the value of America's gross annual production. That figure, which represents the total goods and services produced in one year, is expected to exceed 300 billion dollars before our rearmament is complete.

"Such an economy is capable of building, equipping and supplying our hospitals and health needs as well as providing the necessary implements of defense in sufficient quantities to deter aggressor nations. Civilian health needs are not being neglected."

The responsibility of Catholic hospitals in the emergency was outlined by Dr. Howard A. Rusk, chairman of the health resources advisory committee in the Office of Defense Mobilization.

Speaking at the general assembly June 3 on "Assuring Adequate Professional Staffing for Civilian Hospitals," Dr. Rusk declared that his committee had made three basic assumptions as to the health needs: "First, we should maintain our 1949 physician-population ratio and service. Second, we should meet the additional requirements of civil defense, of industry, of public health services, of rehabilitation services, and of staffing medical schools. Third, we must meet the needs of the armed forces.

"Our committee's studies indicate that by 1954 the nation will need approximately 210,600 physicians. As we are now graduating approximately 6000 physicians a year, 22,000 physicians over and above those now in sight for the year 1954 will be required to maintain the present level of civilian medical services, to meet the special need of industrial mobilization, to meet the projected needs of the armed forces based upon a ratio of 3.7 per thousand troop strength, a figure substantially under that of World War II and also substantially below that presently prevailing."

Dr. Rusk said that the nursing situation is even more critical and that 10,000 more nurses will be required in 1954 than in 1950 to care for the increased population alone.

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NEWS...

"Nothing can be done that will avoid or even reduce this deficit before 1954. Whatever the demands, the present supply of nurses must meet all needs until then or as soon thereafter as the training of additional nurses now in training can be completed."

The rôle pharmacists will play in civil defense planning for atomic attacks was stressed by Leonard J. Piccoli, chairman of the civil defense training program of the New York State Pharmaceutical Association.

Mr. Piccoli said that although federal, state and local civil defense health services will be established by the respective governments, their operation will depend to a large extent on the cooperation and leadership of volunteers from the various health professions, among which the most important will be the pharmacists. "Pharmacists will be able to undertake a great variety of assignments and to handle supply responsibilities at all levels of activity. They will be able to serve as supply officers, will

fill administrative jobs in emergency hospitals and, in some instances, will administer medications, apply dressings, do suturing and other minor surgery under the direction of a physician.

Mr. Piccoli said two kinds of training will be provided for all civil defense workers: (1) instruction in civil defense organization and operation, basic first aid, and rescue operations, and (2) training in defense against atomic, biological and chemical warfare.

In the closing address of the convention the new president of the C.H.A., the Rt. Rev. Msgr. John J. Healy of Little Rock, Ark., called for an increase in patient care in specialized fields, particularly geriatrics, psychiatry and chronically ill. He pointed out that "of more than 800 general hospitals in the United States and Canada, only 110 institutions have beds for special types of care."

Workshops and institutes covering several phases of the hospital field would be continued at convenient geographic locations, Msgr. Healy assured the group. Regional institutes on hospital administration have already been planned in Fargo, N.D.; Wichita, Kan.; Atlanta, Ga.; and Buffalo, N.Y.

Nursing Homes Group to Meet in Boston

KANSAS CITY, MO.—The American Association of Nursing Homes will hold its second annual convention in Boston, September 19 to 22, it was announced at association headquarters here last month. Clifford M. Dahl of Wayne, Neb., association secretary, said the organization held its first convention a year ago.

Purposes of the association are to improve standards of service and administration in nursing homes and to obtain and maintain public and official recognition of the nursing homes as an important part of the nation's health facilities, it was explained.

Specific programs to be undertaken by the association include the development of licensure and legislation, education and public relations.

"Membership in the American Association of Nursing Homes is by member states which have a state law covering licensing or approval of nursing homes and under which law nursing homes are inspected and licensed or approved by one or more departments of state government," Mr. Dahl stated. "At present there are 16 member state associations affiliated with the association," he added.



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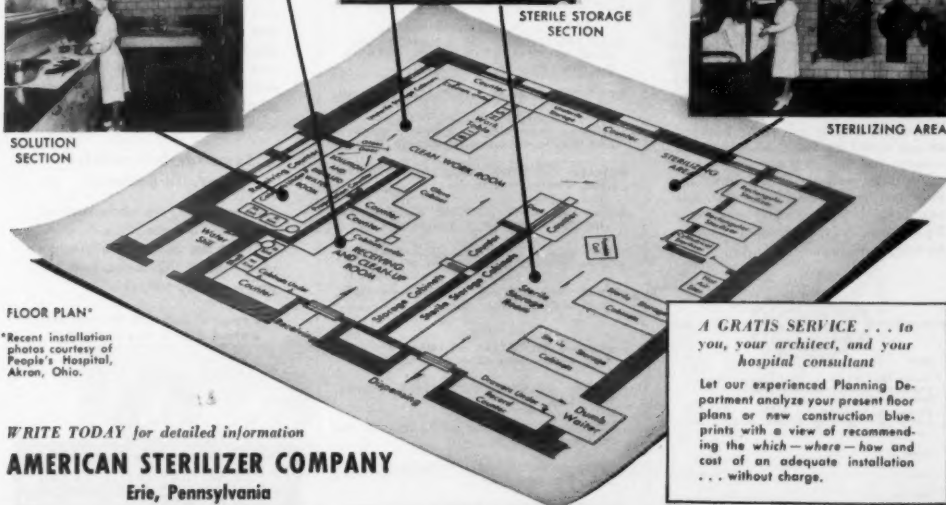


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ABOUT PEOPLE (Continued From Page 92)

tendent of the Wilson County Hospital, Neodesha, Kan. Miss Schabel, who has held the post for more than four years, resigned because of ill health.

Bertha DeLong, superintendent of Tobey Hospital, Wareham, Mass., for the last five years, has resigned.

Iona Olson, formerly supervisor of Atkins Hospital, Hoisington, Kan., is the newly appointed superintendent of the Stafford District Hospital, Stafford, Kan., succeeding Bertha Byer.

COMING MEETINGS

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, St. Louis, Sept. 17-20.

AMERICAN ASSOCIATION OF NURSE ANESTHETISTS, St. Louis, Sept. 16-20.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, St. Louis, Sept. 15-17.

AMERICAN COLLEGE OF SURGEONS, San Francisco, Nov. 5-9.

AMERICAN CONGRESS OF PHYSICAL MEDICINE, Shirley-Savoy Hotel, Denver, Sept. 4-8.

AMERICAN HOSPITAL ASSOCIATION, St. Louis, Sept. 17-20.

AMERICAN LIBRARY ASSOCIATION, Hospital Libraries Division, Chicago, July 8-14.

BRITISH COLUMBIA HOSPITAL ASSOCIATION, Vancouver Hotel, Vancouver, Oct. 16-19.

FLORIDA HOSPITAL ASSOCIATION, Wyoming Hotel, Orlando, Dec. 3, 4.

INTERNATIONAL HOSPITAL FEDERATION, Brussels, Belgium, July 15-21.

KANSAS HOSPITAL ASSOCIATION, Topeka, Nov. 8, 9.

MARYLAND DISTRICT OF COLUMBIA DELAWARE HOSPITAL ASSOCIATION, Statler Hotel, Washington, D.C., Nov. 26, 27.

MONTANA HOSPITAL ASSOCIATION, Billings, Oct. 11, 12.

NATIONAL SOCIETY FOR CRIPPLED CHILDREN AND ADULTS, Palmer House, Chicago, Oct. 3-6.

NEBRASKA HOSPITAL ASSOCIATION, Paxton Hotel, Omaha, Nov. 15, 16.

OKLAHOMA STATE HOSPITAL ASSOCIATION, Tulsa Hotel, Tulsa, Nov. 1, 2.

RHODE ISLAND HOSPITAL ASSOCIATION, Kent County Hospital, Warwick, June 14.

WORLD MEDICAL ASSOCIATION, Stockholm, Sweden, Sept. 15-20.

1952

AMERICAN PROTESTANT HOSPITAL ASSOCIATION, Hotel Statler, Cleveland, Feb. 21, 22.

ARIZONA HOSPITAL ASSOCIATION, Phoenix, Feb. 14-16.

ASSOCIATION OF WESTERN HOSPITALS, San Francisco, May 12-15.

SOUTHEASTERN HOSPITAL CONFERENCE, Atlanta, Ga., April 18-19.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, April 28-30.

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V. D. Seifert

of assistant superintendent of the Fairview Park Hospital, Cleveland. Before joining the staff at St. Luke's Hospital Mr. Seifert served as administrative assistant at Evanston Hospital, Evanston, Ill. He has a bachelor's degree in hospi-

tal administration from Northwestern University and is now completing the requirements for a master's degree in hospital administration from the same school.

William Herin Waite has been appointed administrative assistant at Pennsylvania Hospital, Philadelphia. Having received his master's degree in hospital administration from the University of Minnesota, he served his junior administrative residency at the Rhode Island Hospital, Providence, and is now an administrative resident at Syracuse Memorial Hospital, Syracuse, N.Y.

Mrs. E. I. Young, superintendent of the Morris County Hospital at Council Grove, Kan., has resigned her position, effective July 31. She is a graduate both of Kansas State College and of the University of Kansas and has had special training in hospital management.

Eleanor M. Brown will have as her successor as superintendent of the Centre County Hospital, Bellefonte, Pa., Edna Mae Eckert, R.N. Mrs. Eckert is the former superintendent of the hospital at Lock Haven, Pa., and was also a science instructor and assistant director of nurses at St. Agnes Hospital, Philadelphia, and Mother Cabrini Hospital, Chicago.

Capt. Albert T. Walker has succeeded R./Adm. Warwick T. Brown as head of St. Albans Hospital, Long Island, N.Y., a naval institution. Capt. Walker of the Navy Medical Corps is a former surgeon of the Pacific Fleet. R./Adm. Brown is now medical officer of the Fifth Naval District at Norfolk, Va.

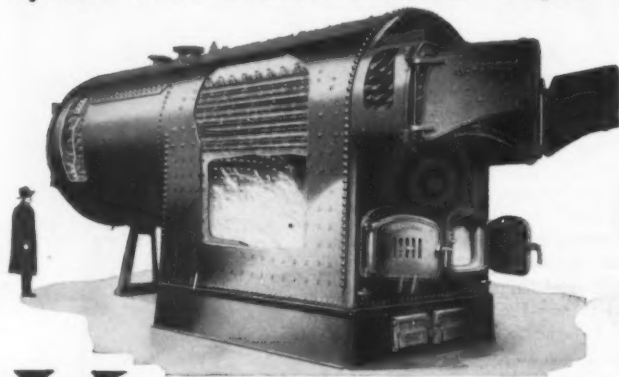
Kenneth D. Moburg is the new administrator of Schoolcraft Memorial Hospital, Manistique, Mich., succeeding James I. Boyce. Mr. Moburg did his graduate work in hospital administration at Northwestern University and served his residency at Grace Hospital, Detroit.

Dwayne L. Hall has been appointed administrator of the City Hospital, Bowling Green, Ky. Upon completion of the 70 bed addition now under construction he will assume the duties of administrator of the Bowling Green-Warren County Hospital of 125 beds. Mr. Hall, who received a master's degree in hospital administration from the University of Denver in June, served his administrative residency under the preceptorship of S. A. Ruskjer, deputy director of the Louisville and Jefferson County Board of Health, Louisville, Ky., and administrator of Waverly Hills Sanatorium.

Robert Sandahl, who received his master's degree in hospital administration from Northwestern University in June, has been named assistant administrator of the Wausau Memorial Hospital, Wausau, Wis. He succeeds Olive M. Graham, R.N., who has been in charge of the hospital since its opening in 1924.

Nick Rajacich is the new administrative resident at Johns Hopkins Hospital, Baltimore. For the last year Mr. Rajacich has been working on his master's degree in hospital administration at the University of Minnesota. He formerly was associated with St. Mary's Hospital, Rochester, Minn.

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- Garfield County Hospital, Jordan, Montana.
- National Institute of Health, Bethesda, Md.



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Dr. S. M. Wingo is the medical director of the new 120 bed Tennessee Tuberculosis Hospital, Chattanooga, which will open about August 1. The business manager will be C. W. Wright.

Department Heads

L. W. Hammett, purchasing director of Michael Reese Hospital, Chicago, has resigned his position to accept the vice presidency of the Bio Ramo Drug Company of Baltimore, in charge of production. He is the former purchasing director of Sinai Hospital at Baltimore.

Joseph Heeb is the new purchasing agent for the Sisters of St. Joseph's mother house at Wichita, Kan., which is the central purchasing department for the 11 hospitals operated by the Order in that district. Formerly he was purchasing agent at Methodist Hospital, Sioux City, Iowa.

Sister M. Noemi has been named director of the St. Joseph's School of Nursing, Alliance, Neb., succeeding Sister M. Theola, who has been transferred to a similar position at St. Joseph's Hospital School of Nursing, Minot, N.D.

Miscellaneous

Lt. Col. Leonard P. Zagelow, USAF Medical Service Corps, has been assigned to the requirements and stock control branch of the air force surgeon general's office and will be in charge of the office. All the requirements and stock control offices of the three services are located with the armed services medical procurement agency in New York. During the war Col. Zagelow served as medical supply officer and later executive officer in the office of the theater surgeon of the Southwest Pacific. He also has been commanding officer of the fifth medical depot and director of the storage division, San Antonio Medical Depot.

Dr. Hugo V. Hullerman has resigned as assistant director of Rhode Island Hospital, Providence. He has accepted the post of director of hospital services with the United Hospital Fund of New York, a central fund-raising organization for 86 hospitals in that city. In his new position he will supervise and coordinate services to hospitals and will expand the activities of the fund into new fields whenever feasible. Dr. Hullerman formerly served in the Illinois State Health Department and then was assistant director of the American Hospital Association in charge of professional and educational activities. He has been chairman

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Minimum care required
Portable

highly volatile anesthetic agents are used because of its provision for the dissipation of static electricity. Another remarkable feature: There's nothing to get out of order—the only care required is lubrication! Complete details on request.



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of the health division of the Council of Community Services at Providence.

Dr. William Wartman, director of the pathology department at Passavant Memorial Hospital, Chicago, has been elected a member of the board of trustees and assistant secretary of the American Board of Pathology, the specialty licensing board for pathology.

Lt. Col. Woodrow C. Herbert has been assigned as the medical supply officer for the air materiel force under the commander-in-chief, U.S. Air Force in Europe. The air materiel force is responsible for the operation of air force

off-base hospitalization and for the operation of the air force medical materiel system at depot level. During World War II he was in charge of the medical supplies of the eastern coast of Africa, and he also served in the Greek theater as medical supply officer for the Joint Command. Prior to his new assignment, Col. Herbert was assigned as professor of military science and tactics at the University of California while finishing work on a master's degree in pharmacy.

Dr. John A. Trautman has been appointed director of the National Institutes of Health's new clinical center for

medical research at Bethesda, Md. Dr. Trautman, now medical officer in charge of the Public Health Service's Marine Hospital at Staten Island, N.Y., assumes his new post July 1, succeeding **Dr. Jack Masur**, assistant surgeon general, who became chief of the Bureau of Medical Services, Public Health Service, earlier this year. The clinical center will be the largest research institution in the United States when it opens in 1952, and Dr. Trautman's responsibility will be the coordination of patient care and services with laboratory and clinical research. He is an associate examiner of the National Board of Medical Examiners.

Dr. Emil Frankel, director of the division of statistics and research of the New Jersey State Department of Institutions and Agencies, has been made an honorary member of the New Jersey Hospital Association.

George Bugbee, executive director of the American Hospital Association, was honored recently by the Northwestern University chapter of Alpha Delta Mu, professional fraternity in hospital administration, when **Dean Conley**, executive secretary of the American College of Hospital Administrators, presented him with an honorary key of membership on the fraternity's behalf.

Mrs. Mildred L. Bradshaw, director of nurses at Leigh Memorial Hospital, Norfolk, Va., has been elected president of the National Association for Practical Nurse Education succeeding **Ella M. Thompson** of New York City, who was elected secretary. New members of the board of directors are **Leora Stroup**, Grand Rapids, Mich., **Mrs. Helen Hermann**, Detroit, and **Mrs. Alfred G. Kay** and **Joseph V. LeRoy**, both of New York City.

J. Howard Buzby, president of the board of trustees of the Atlantic City Hospital, Atlantic City, N.J., has been elected treasurer of the New Jersey Hospital Association.

Lucile Petry, assistant surgeon general and chief nurse officer of the Public Health Service, received the honorary degree of doctor of science at Boston University's commencement exercises June 4. Miss Petry, who attended the first World Health Assembly in Geneva in 1948 as the only nurse among representatives of 52 participating nations, is the former director of the cadet nurse corps. She was recently appointed to the expert committee on nursing of the World Health Organization.

Ruth Johnson, a Public Health Service officer and a specialist in midwifery, is

While the patient lies abed.

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NEWS...

the first nurse to be assigned to Iran under the Point 4 Program. She will join the health mission in Teheran as chief nurse adviser. Miss Johnson's work will be to advise the Iranian government on nursing matters and to help organize and supervise the operation of local village demonstration teams for the training of Iranian people as public health workers. She served in Japan for two years with the Eighth Army Civil Affairs Program; she was in Egypt, Greece and China from 1944 to 1947, assigned to UNRRA, and she also served two years in Panama with the Canal Zone Health Department.

Charles W. Flynn has been appointed executive secretary of the Mississippi State Hospital Association, after resigning as administrator of the District Two Community Hospital, Durant. He was formerly connected with the North Mississippi Community Hospital, Tupelo.

Deaths

Will Ross, president of Will Ross, Inc., of Milwaukee, manufacturer and distributor of hospital and sanatorium equipment and supplies, died May 31 at the age of 62. While still in his teens, Mr. Ross developed tuberculosis. His fight against the disease led to his interest in sanatoriums and other institutions serving the sick, and his successful business was founded on that interest.

Mr. Ross by no means confined his enthusiasm for health work to his hospital equipment and supply business but became nationally known in both lay and medical circles. In 1944 he was made president of the National Tuberculosis Association, the second layman to hold this office. In 1943 he received the Hoyt E. Dearholt medal of the Mississippi Valley Conference for his contributions, particularly for his 30 years of work with the Wisconsin Anti-Tuberculosis League.

His local activities included directorships in the Red Cross, Y.M.C.A. and Milwaukee-Downer College. Recently he had been working steadily for the Milwaukee War Memorial Center.

Robert Bacon, who was serving as administrator of the Hoag Memorial Hospital, Newport, Calif., which is now in course of construction, died unexpectedly of a heart attack.



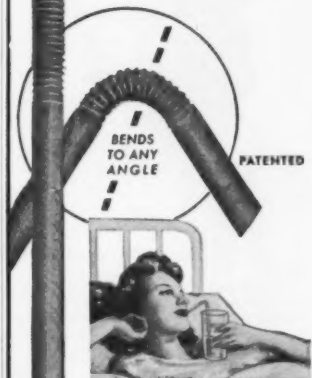
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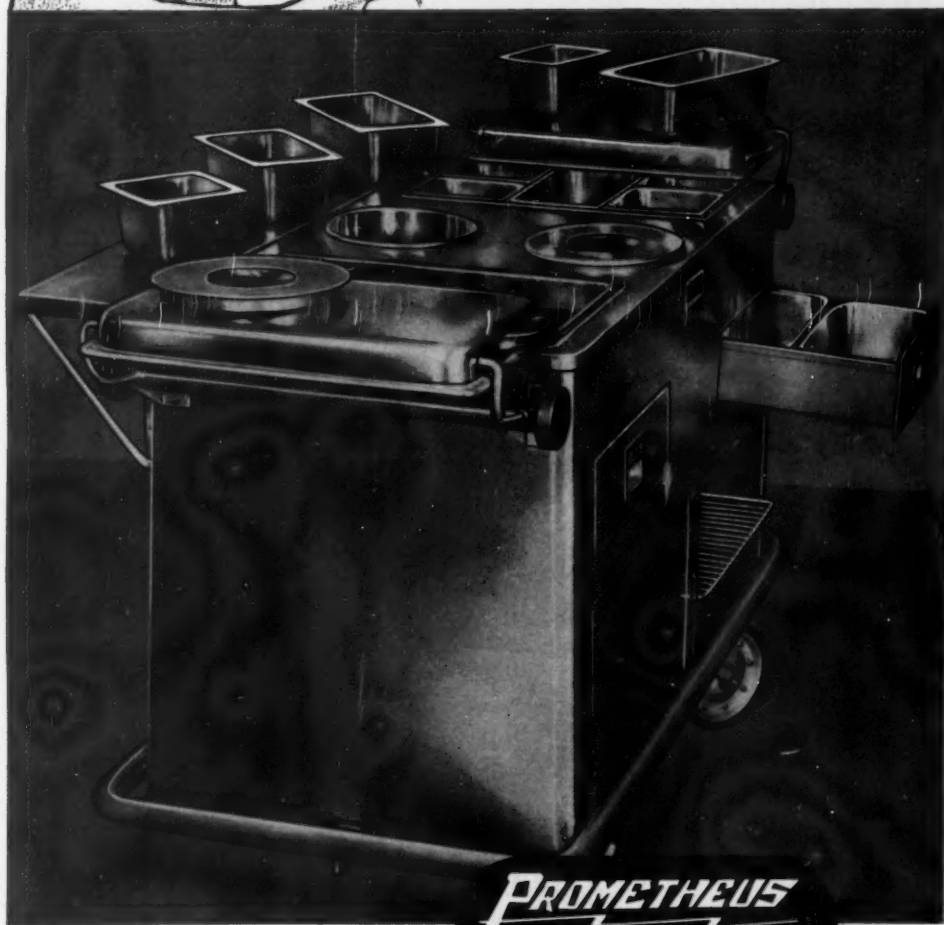
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one compact unit for all foods

Make your own inset arrangements to fit your needs. Simply arrange the various size rectangular and square insets to suit your selective menus. Note the two round wells for soups, etc., and the two heated drawers for bread and rolls. Other models available with additional round wells.

Made entirely of heavy gauge STAINLESS STEEL, the Prometheus "DIET-MASTER" is built for years of service.

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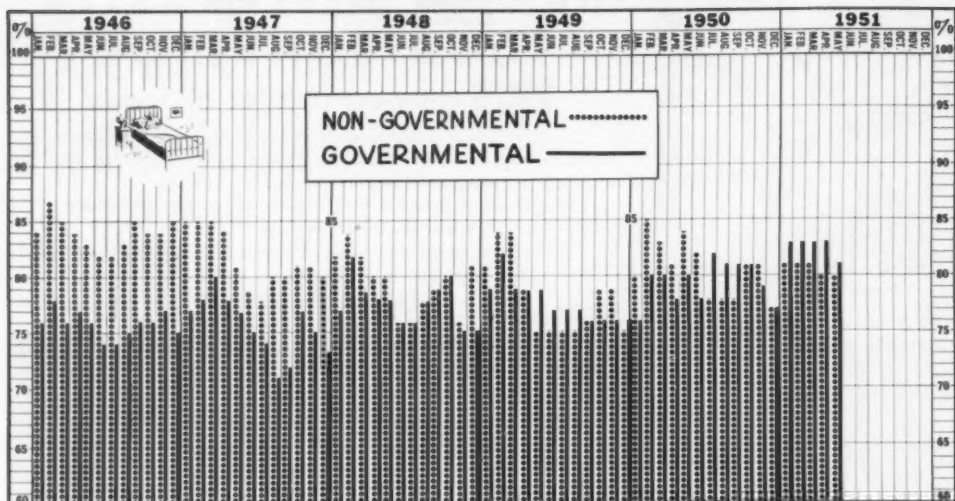


Write for catalog of Prometheus Operating Lights, Sterilizers, Food Conveyors and other hospital equipment.

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Hospital Construction Level Remains High



Occupancy of voluntary hospitals reporting to the Occupancy Chart for the month of May was 79.5 per cent of capacity, slightly lower than the occupancy reported for April and less than the figure for May 1950. Occupancy

of government hospitals reporting for the month was 81.2 per cent, approximately the same as the occupancy reported for the same month last year.

New construction reported to The MODERN HOSPITAL totaled \$61,738,501

for the latest period. This was lower than the total reported for the corresponding period a year ago, but the total remained higher than last year's. In the latest 1951 period there were 20 new hospitals and 10 additions.

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- wholly automatic precision controls
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Engineered to meet the busy roentgenologist's needs, the Mattern DGS-200 provides fully automatic controls and the special plus features that mean utmost efficiency.

Literature on the DGS-200 is available on request.

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Mattern plus features:

wholly automatic controls—including selectors which choose proper circuits, compensations, and regulations necessary to produce better radiographs. Phototimer for all Bucky radiographs; DGS-200 also permits spot radiography with phototimer.

simplified installation—no installation difficulties or delays. Custom-built with floor-coiling tubestand of desired height.

double-focus rotating anode X-ray tube is perfectly counterbalanced, easily positioned, smooth-moving on precision bearings.

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Mattern transformer—compact, offering consistent output, and with 50% extra reserve power without added bulk. Mattern equipment offers long life, and few service requirements.

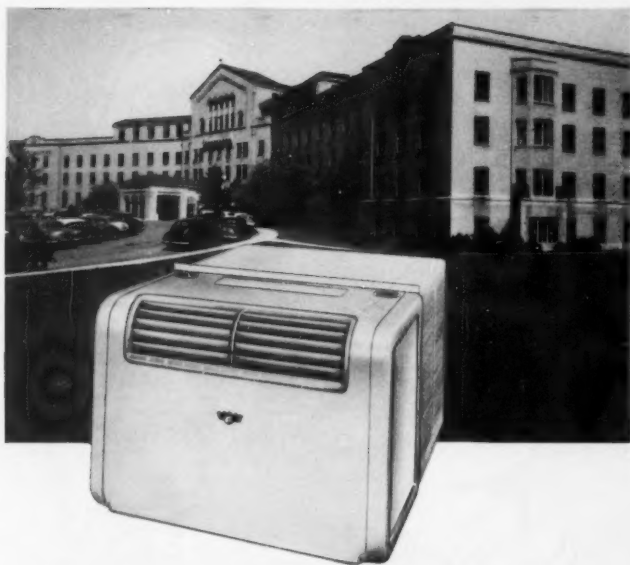
silent, rugged, motor-driven tilt table with powerful, smooth-running, almost inaudible worm-gear drive. Sturdily built, engineered with more-than-adequate safety factors. Like all other Mattern units, the DGS-200 lasts longer, requires less adjustment and general repair services.



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The MODERN HOSPITAL



Good Samaritan Hospital Finds Frigidaire Solves Air Conditioning Problem

Maintaining a comfortable temperature in the nursery had always been a problem at the Good Samaritan Hospital, Dayton, Ohio. First, the staff tried fans. Then air was blown over ice to bring relief to the babies and avoid heat rash and fevers on hot, humid days.

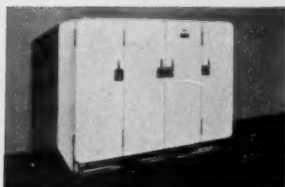
In 1947, three $\frac{1}{2}$ hp Frigidaire Room Air Conditioners were installed in the nursery. Since then, the temperature can be kept at 75°, the humidity between 50% and 60%. And twenty more basinettes have been placed in the same room. The hospital is now using its Frigidaire Conditioners for the fourth consecutive summer.

The Good Samaritan like so many other hospitals has discovered that Frigidaire products always give years of trouble-free service at *really* low operating costs. So whatever your hospital's refrigeration or air conditioning need, call your nearby Frigidaire Dealer or the District Headquarters office that serves you. Look for the name in the Yellow Pages of your phone book under "Refrigeration Equipment." Or write Frigidaire Division of General Motors, Dayton 1, Ohio. In Canada, Leaside (Toronto 17), Ontario. (Ask, too, for Frigidaire's *free* Refrigeration Security Analysis of your refrigeration costs!)

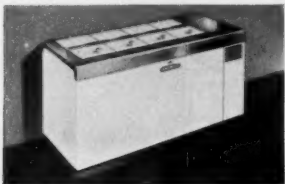
FRIGIDAIRE

Over 400 commercial refrigeration and air conditioning products—
most complete line in the industry.

Here are some of the ways Frigidaire
can serve your Hospital



Frigidaire Reach-In Refrigerators keep foods fresher longer, cut shrinkage, spoilage to minimum. Sizes range from 17 cu. ft. to 62 cu. ft. models. Models also available with special interiors for safekeeping of biologicals and medicinals.



Frigidaire Low-Temperature Cabinets provide safe cold for frozen foods and ice cream. Ideal for hospital cafeterias and diet kitchens. These cabinets are powered by Frigidaire's famous Meter-Miser compressors, backed by a 5-Year Warranty.



Frigidaire Compressors operate on a trickle of current—save hospitals money. Used with walk-in coolers and in other refrigeration installations. Famous Meter-Miser available in $\frac{1}{4}$, $\frac{1}{2}$, and $\frac{3}{4}$ hp sizes. Reciprocating compressors up to 25 hp.

Other Frigidaire products for hospitals include large self-contained and central system air conditioners, water coolers, beverage coolers and ice makers.



TO COMFORT THE PATIENT ... Cool beverages in a light-weight glass that's extra strong



3 double-bulge Heat-Treated tumblers offer a sure grip, even when wet: 9½ oz. (water), 12 oz. (iced tea), 5 oz. (juice).



All Libbey Heat-Treated tumblers have this special "H-T" marking—your assurance of 3-5 times longer-lasting glassware.

Nothing comforts a trembling, feverish patient more than the sight of a cool, refreshing beverage. It is even more comforting if the beverage is in a light-weight tumbler that is easy to grip.

All Libbey Heat-Treated tumblers have light-weight, thin sides and bottoms—give a cool, smooth feel that contributes much to the patient's sense of well-being. And at no sacrifice in strength and durability! ... because Libbey Heat-Treated tumblers are specially processed after molding to stand up 3-5 times longer

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All Libbey Safedge tumblers have chip-resistant rims ... at the spot where most tumblers chip first! *Safedge* means "safety" for staff and patients. It also means savings through lower cost, less breakage, smaller needed inventory ... protected by the famous guarantee: "A new glass if the rim of a Libbey's Safedge glass ever chips!" Ask your supplier for samples and prices, or write direct to Libbey Glass, Toledo 1, Ohio.

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The MODERN HOSPITAL

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ADMINISTRATOR—100-bed hospital or larger; experience includes administrator of 100-bed hospital, eight years as assistant administrator of 250-bed hospital, duties also included purchasing, personnel and public relations; 6 years' public accounting and auditing experience; available within 60 days. MW 43, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

LIBRARIAN—Medical record; seven years' experience in approved hospitals; college degree; graduate University of Pennsylvania School for Medical Record Librarians; capable supervision, reorganization, top references; 30; single; no dependents. MW 44, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

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ASSISTANT ADMINISTRATOR—M.H.A. Degree, University of Chicago; 4 years administrative assistant, 185-bed hospital; east.

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ADMINISTRATOR—29; B.S., M.S., Administration; 2 years, hospital administrative residency; 2 years, director 100-bed hospital; 4 years, director, 300-bed hospital; nominee, ACHA.

ADMINISTRATOR—B.S., M.S., Hospital Administration 3 years, auditor, 150-bed hospital; 2½ years, assistant administrator, 250-bed hospital; seeks 100-bed hospital.

WOODWARD—Continued

ANESTHESIOLOGIST—Part I completed; eligible Part II American Boards; 3 years, teaching and associate chief, 300-bed hospital.

RADIOLOGIST—Diplomate, certified in both; well trained; associate director, 750-bed teaching hospital and faculty member, university medical school.

PATHOLOGIST—Diplomate, pathologic anatomy; eligible clinical pathology, 2 years; 2 years, instructor and 1 year, associate professor, university medical school.

THE MEDICAL BUREAU Burneice Larson, Director Palmolive Building Chicago 11, Illinois

ADMINISTRATOR—Medical; A.B., M.D., M.B.A. Hospital Administration; several years, assistant administrator, university hospital; five years, director, voluntary hospital, 300 beds; FACHA.

ADMINISTRATOR—M.H.A. Hospital Administration; year's preceptorship, 400-bed hospital; year's administrative internship and two-year administrative assistantship, teaching hospital; interested in directorship small hospital or assistant directorship large hospital.

ADMINISTRATOR—Lay; B.S. Business Administration, eastern university; since 1942, director, voluntary, general hospital, 350 beds; excellent experience in modernization, enlargement and planning of hospital facilities, fund raising, public relations; FACHA.

ADMINISTRATOR—Graduate nurse; B.S., Hospital Administration; four years' supervisory experience before specializing; recently completed administrative residency, teaching hospital; in thirties.

ANESTHESIOLOGIST—Past eight years, director, department of anesthesiology, 700-bed, general hospital; Part I American Board completed.

PATHOLOGIST—Of outstanding qualifications; four years, assistant professor of pathology; six years, professor and head department pathology, university medical school and director of pathology, 350-bed hospital; Diplomate, F.C.A.P.

RADIOLOGIST—Diplomate American Board; Fellow American College of Radiology; seven years, director, radiology, 300-bed hospital; now radiologist, group limiting practice to radiology; prefers directorship, hospital department.

For further information, please write Burneice Larson, Medical Bureau, Palmolive Building, Chicago.

(Continued on page 172)

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ADMINISTRATOR—Assistant; lay or medical; for progressive eastern Canadian hospital of more than 200 beds with large expansion program now under way; excellent opportunity for qualified person who has had administrative experience in the fields of personnel management, purchasing, public relations, as well as in other departments. MO 26, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ANESTHETIST—Nurse; new modernly equipped 44-bed hospital; attractive salary, good living conditions. Lauderdale County Hospital, Ripley, Tennessee.

ANESTHETIST—Nurse; for 550-bed hospital connected with medical college; salary \$400 per month. Apply to Dr. Alice McNeal, Director, Department of Anesthesiology, Jefferson Hillman Hospital, Birmingham 5, Alabama.

ANESTHETIST—Nurse; for 300-bed hospital; four anesthetists now on service; salary open. Apply, D. W. Hartman, Superintendent, The Williamsport Hospital, Williamsport, Pennsylvania.

ANESTHETIST—Nurse; registered; for 63-bed modern hospital; two anesthetists employed; good salary and hours; liberal sick leave, vacation and holiday program; good working conditions. Apply, Administrator, Centre County Hospital, Bellefonte, Pennsylvania.

ANESTHETIST—Registered nurse; for 165-bed hospital with large expansion program under way; located in the sunshine city of America on the beautiful gulf beaches; salary \$325 per month, plus partial maintenance; full maintenance obtainable if desired. Apply by letter giving full details of training and experience to, Administrator, Mound Park Hospital, St. Petersburg, Florida.

ANESTHETIST—R.N., fully experienced for small general hospital; excellent salary and maintenance. Write, Mr. Herman R. Goldberg, Administrator, Northern Liberties Hospital, 7th & Brown Streets, Philadelphia 23, Pennsylvania.

ANESTHETIST—Nurse; wanted for 200-bed, completely modern hospital; community of 28,000, one and one-half hours from beach resort; salary open; complete maintenance furnished. Contact Mark Stanton, Administrator, The McLeod Infirmary, Florence, South Carolina.

ANESTHETIST—Well trained and experienced; general hospital of 141 adult beds for white women only; salary open; maintenance if desired. Apply, Director, The Hospital for the Women of Maryland, Baltimore 17, Maryland.

ANESTHETISTS—Nurse; two; needed for the Lying-In Department of the New York Hospital; experienced in obstetrics and gynecologic anesthesia; attractive salary and good personnel policies; vacation, one month; 40-hour week; quarters available if desired. Apply, Chief Anesthetist, Lying-In Department, M-522, New York Hospital, New York 21, New York.

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ANESTHETISTS—Nurse: two needed; 200-bed hospital, fully accredited active member of the AHA; salary \$350-400 monthly, maintenance optional; vacation, sick leave. Apply Administrator, Franklin Square Hospital, Baltimore 23, Maryland.

ANESTHETISTS—Immediate openings for two qualified nurse anesthetists in fully approved 210-bed hospital; medical supervision. Write Daniel C. Moore, M.D., Director of Anesthesiology, Virginia Mason Hospital, Seattle 1, Washington.

DIETITIAN—Qualified; position now open; new 120-bed hospital to be started soon. For information apply, Superintendent, Charlotte County Hospital, St. Stephen, New Brunswick.

DIETITIAN—Experienced; for administrative assistant to chief dietitian. Apply, Personnel Office, Toussaint Infirmary, New Orleans, Louisiana.

DIETITIAN—Registered; wanted for a fully approved 150-bed hospital; good salary and pleasant surroundings. Apply Mother Marie, Maryview Hospital, Portsmouth, Virginia.

DIETITIAN—322-bed hospital; starting salary \$175 per month, plus meals and laundry. Write Director, Hamot Hospital, Erie, Pennsylvania.

DIETITIAN—For new 118 pediatric hospital; minimum salary \$225 per month. Write to the Executive Dietitian, Raymond Blank Memorial Hospital, Des Moines, Iowa.

DIETITIAN—Therapeutic; 300-bed approved general hospital, in central Pennsylvania. Apply, D. W. Hartman, Administrator, The Williamsport Hospital, Williamsport, Pennsylvania.

DIETITIAN—Administrative, ADA member; 125-bed general hospital. Frederick Memorial Hospital, Frederick, Maryland.

DIETITIANS—Baltimore City Hospitals, Baltimore, Maryland; invites inquiries about positions for dietitians, which are now open; dietary department is rapidly expanding and currently serves 6000 meals per day; good salaries and desirable personnel practices.

DIRECTOR—Educational; for 377-bed hospital with accredited school of nursing; basic sciences taught at Norfolk Division, College of William and Mary; effective student government; Degree in Nursing Education and teaching experience essential; excellent personnel policies; salary commensurate with preparation; complete maintenance available; position open June 1st; must be filled by August 1st. Apply Director of Nurses, Norfolk General Hospital, Norfolk, Virginia.

DIRECTOR—Educational; 275-bed hospital with state approved school; student body 110; well equipped hospital located in central Ohio; master's degree preferred; experience required; salary open. MO 27, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

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DIRECTOR OF SCHOOL OF NURSING—Associate; for 325-bed general hospital with approved school of nursing; student body 140; well equipped hospital located in a fine residential section of an Ohio city, near Detroit; Master's Degree preferred; experience necessary; position available July 1, 1951. MO 21, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

DIRECTOR OF NURSES AND NURSING SCHOOL—For 163-bed, fully approved general hospital, with large expansion program under way; located in the sunshine city of America, on the beautiful gulf beaches; 51 students in school; B.S. Degree and experience required; salary open. Apply by letter, giving full details of training and experience to, Administrator, Mound Park Hospital, St. Petersburg, Florida.

(Continued on page 174)

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Pads stay loose
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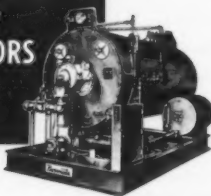
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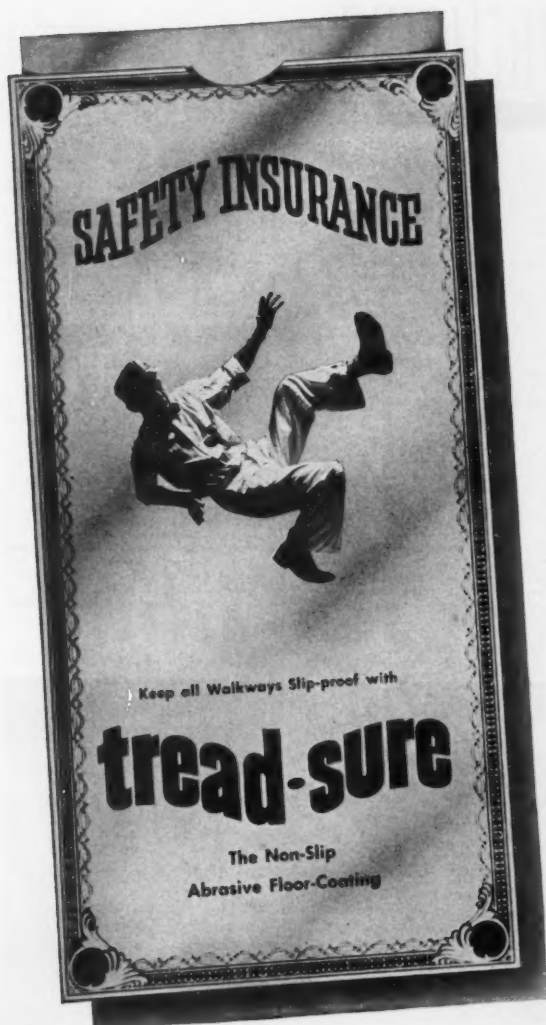
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Tread-Sure is resistant to gasoline, alcohol, oil, grease, detergents, industrial waste and many types of acids. Tread-Sure provides a non-skid safety footing, giving the worker confidence and security by reducing accident hazards.

Tread-Sure maintains traction and resiliency and is comfortable to stand on. Designed for exterior as well as interior use, it may be brush applied over other paint or direct to unpainted surfaces. Used as it comes from container. Three non-glare colors—Battleship Grey, Red, Green.

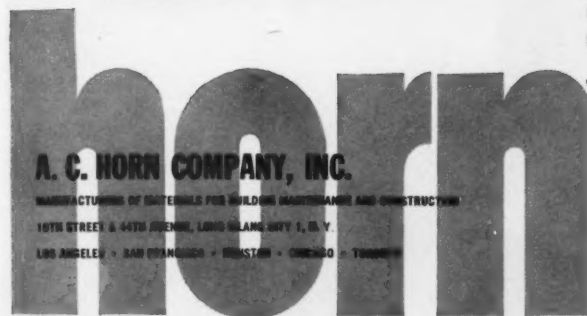
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ME-51

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DIRECTOR OF NURSES—Assistant; B.S. Degree; experience of 1 to 2 years in the field; Pennsylvania registration; salary, \$2700 to \$3000 a year; liberal personnel policies; 300-bed hospital. Apply to the Director of Nurses, Lancaster General Hospital, Lancaster, Pennsylvania.

DIRECTOR OF NURSING—For 1700-bed psychiatric state hospital, South Dakota; B.S. Degree and experience in administration required; psychiatric affiliation program being developed; full maintenance; salary \$325. Apply F. W. Hass, Superintendent, Yankton State Hospital, Yankton, South Dakota.

HOUSEKEEPER—Executive; for hospital; one with hospital experience and training preferred. Apply Director, Franklin Square Hospital, Baltimore 23, Maryland.

INSTRUCTOR—Assistant clinical; for 192-bed general hospital; student enrollment 75; medical surgical nursing, qualified to teach pharmacology; salary open; position available now. MO 29, The Modern Hospital, 919 N. Michigan, Chicago 11.

INSTRUCTOR—Clinical; for practical nursing students in 135-bed hospital; formal and clinical teaching and supervision of students

in a state and nationally accredited school; starting monthly salary \$200; vacation and sick leave; new nurses' home now under construction. Write, Director of Nurses, St. Mary's School of Practical Nursing, Pierre, South Dakota.

INSTRUCTOR—Clinical; 300-bed hospital; average student body of 150; fully approved school of nursing; experienced person preferred, but will consider a recent graduate; starting salary open; good personnel policies. Apply, Director of Nurses, Lancaster General Hospital, Lancaster, Pennsylvania.

INSTRUCTOR—Nursing arts; for teaching staff of 450-bed hospital; 165 students. Apply stating qualifications to Director of Nursing, General Hospital, Saint John, New Brunswick.

INSTRUCTOR—Science; for 100-bed general hospital school of nursing; good working and living conditions; salary open, depending upon training and experience. Apply, Director of Nursing Science, Pulaski Hospital, Pulaski, Virginia.

INSTRUCTOR—Nursing arts; 125-bed general hospital; salary open; Degree required; liberal personnel practices. Apply to the Director of Nurses, Frederick Memorial Hospital, Frederick, Maryland.

INSTRUCTOR—Nursing arts, White Plains Hospital School of Nursing. Apply to Director, School of Nursing, White Plains Hospital, White Plains, New York.

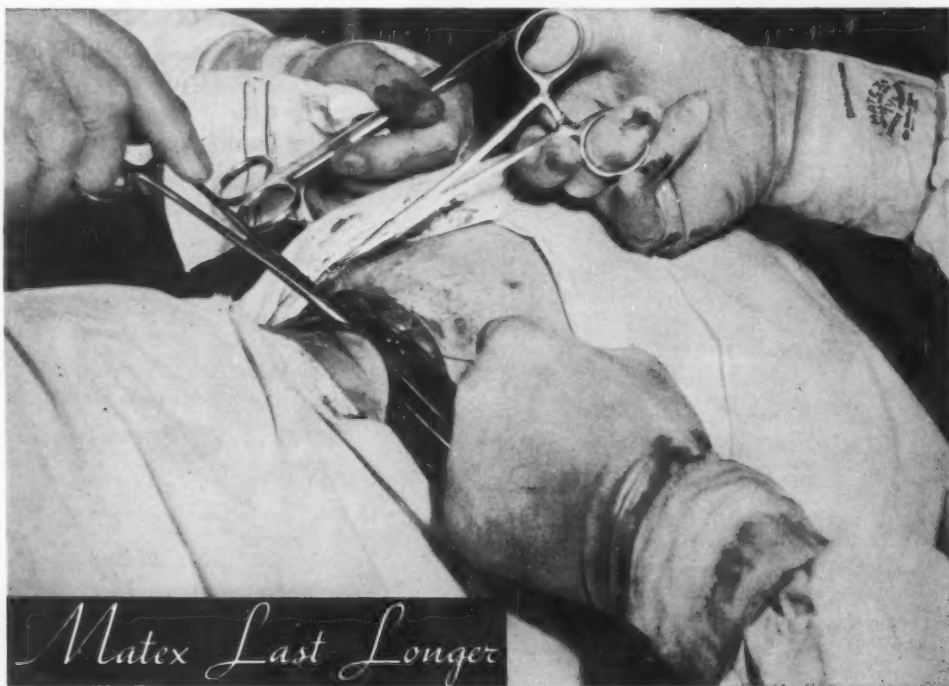
INSTRUCTOR—Nursing arts; for nursing arts I and II; assistant provided; pre-clinical enrollment 30; salary open. MO 29, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

INSTRUCTORS—Clinical; 2; medical and surgical for 325-bed general hospital; degree and experience preferred. Apply, Director, School of Nursing, The Toledo Hospital, Toledo, Ohio.

INSTRUCTORS—Science and clinical; immediate vacancy; for approved school of nursing; 200-bed general hospital; vacation and sick leave policy. Apply Personnel Director, Franklin Square Hospital, Baltimore 23, Maryland.

INSTRUCTORS—Nursing arts instructor; salary \$275-\$325; degree and experience required; Medical and surgical clinical instructors; salary \$250-\$300, degree and experience preferred; fine opportunity in newly expanded 300-bed hospital in college town; educational facilities include large modern nursing arts laboratory, class rooms and ward conference rooms; all types of equipment for visual aids are available; liberal personnel policies including social security. Apply, Director of Nurses, Bronson Methodist Hospital, Kalamazoo, Michigan.

(Continued on page 174)



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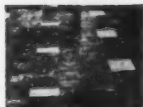
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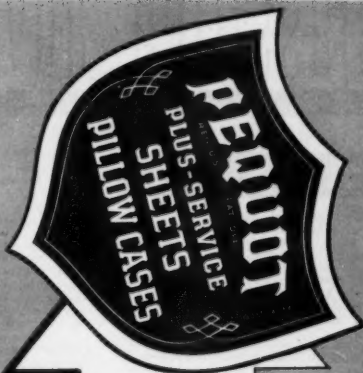
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POSITIONS OPEN

LIBRARIAN—Medical record; 300-bed general hospital in central Pennsylvania; salary open. Apply, The Williamsport Hospital, Williamsport, Pennsylvania.

MISCELLANEOUS—Well qualified Director of nurses for 250-bed North Carolina Hospital; also Dietitian, ADA, for same institution. Memorial Mission Hospital, Asheville, North Carolina.

MISCELLANEOUS—Educational director; for school of nursing; part of a centralized collegiate program, in a 285-bed general hospital; also, Clinical instructor in medical, surgical; Evening supervisor and Obstetrical head nurse; salaries good and commensurate with preparation. Apply Sister M. Victorine, C.S.A., Administrator, St. John's Hospital, Cleveland, Ohio.

MISCELLANEOUS—General duty nurses; two; 55-bed general hospital; 20 miles from Washington, District of Columbia; full maintenance; \$155 per month; modern and comfortable nurses' home; 12 days sick leave; also Operating room assistant; \$175. Apply, Administrator, Montgomery County General Hospital, Olney, Maryland.

MISCELLANEOUS—New Mexico needs Supervisor of hospital licensure and Hospital nurse consultant. Write, Merit System, Box 939, Santa Fe, New Mexico.

MISCELLANEOUS—Operating room nurse; preferably one with special training or experience; Laboratory technician; registration preferred. Apply, giving details to Superintendent, The Soldiers' Memorial Hospital, Campbellton, New Brunswick.

MISCELLANEOUS—Surgical clinical instructor; immediately; salary open; also General duty nurses for 250-400-bed hospital; salary \$205 plus two meals and the laundry of four uniforms; \$15 differential for evening and night duty. MO 25, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

NURSE—Registered; for general duty; meals while on duty and laundry of uniforms. Apply Business Manager, Floyd County Co-operative Hospital, Lockney, Texas.

NURSE—Graduate; experienced in tuberculosis preferable; good salary; full maintenance. Wyoming Tuberculosis Sanatorium, Basin, Wyoming.

NURSES—Staff; eligible for registration in Michigan; needed for all services in modern 250-bed hospital; salary \$236 per month for 40-hour week; 6 months increase; \$10 extra for 8-11 and 11-7 duty; 7 paid holidays; 2 weeks vacation and 12 days sick leave per year; cafeteria meal service; laundry furnished. Apply, Superintendent of Nurses, Pontiac General Hospital, Pontiac, Michigan.

NURSES—Graduate; junior staff for delivery room, infant care and general duty; beginning salary \$205 for 44-hours per week; increase

after six months, one year and two years; \$20 month differential for evening and night duty. Apply, Superintendent of Nurses, St. Louis Maternity Hospital, 630 South Kingshighway, St. Louis 10, Missouri.

NURSES—Graduate staff; for 44-hour week, day, evening or night shifts or rotating; for new 300-bed hospital which will be open in August 1951; applications being received for all departments; vacancies at the present time in 110-bed hospital for evening nurses. Write, Mildred B. Whitte, Assistant Director of Nursing, Methodist Hospital, Houston, Texas.

NURSES—Practical; graduates of schools approved by Michigan Board of Registration for nurses and trained attendants; \$186 per month; 40-hour week; paid vacation, holiday time and accumulative sick time; regular pay increases. Write, Superintendent of Nurses, Pontiac General Hospital, Pontiac, Michigan.

NURSES—Registered; floor supervisors and general duty for new 74-bed hospital; 40-hour week; good salary; furnished duplexes available. Contact, Miss Bernice Harris, Administrator, Tulare District Hospital, Tulare, California.

NURSES—Graduate; full or part-time; for 150-bed general hospital with a modern new addition of 150 beds to be opened in the fall; located in the heart of the Montana Rockies, in state university town; personnel policies in accord with those requested by the Montana State Nurses' Association. For information write, Director of Nursing Service, St. Patrick Hospital, Missoula, Montana.

(Continued on page 178)



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POSITIONS OPEN

NURSES—Registered; for general staff duty in the 85-bed private section of the Rhode Island Hospital; 44-hour week, rotating shifts, good working conditions. Apply, Nurse Director of the Jane Frances Brown, Providence 3, Rhode Island.

NURSES—General staff; Toledo Hospital of Toledo, Ohio, has a few vacancies for general staff nurses; present salary scale \$2260-\$2640 with partial maintenance. For information write, Associate Director, Nursing Service, Toledo Hospital, Toledo, Ohio.

NURSES—Staff; for a general hospital on medical, surgical and obstetric services; also vacancies on operating room staff; good personnel policies. Apply to Director of Nursing, Buffalo General Hospital, 100 High Street, Buffalo, New York.

NURSES—Staff; for 600-bed modern tuberculosis hospital with university affiliation; excellent salary; 44-hour week; 28 days vacation; 15 work-days sick leave per year; cumulative to 90 days; retirement plan; modern nurses' home with all private rooms; excellent food; laundry furnished. For additional information write or wire, Director of Nursing Service, Dunham Hospital, Cincinnati 5, Ohio.

NURSES—Staff; modern 60-bed hospital located in south Georgia; town of 6000 population; all modern conveniences; new nurses home with private rooms and connecting baths; beginning salary \$175 per month and full maintenance; increase after 3 months. MO 20, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

NURSES—General duty; for 340-bed general hospital; starting salary \$175 per month with maintenance; \$200 per month with partial maintenance; rotating shifts; two weeks' vacation; 30 days' sick leave; 6 holidays yearly with pay; 44-hour week; college courses available through night classes at local university. Apply Director of Nursing, Greenville General Hospital, Greenville, South Carolina.

NURSES—Registered; for 5½-day week; paid vacations; 8 paid holidays per year; permanent employment; starting salary for general duty \$220 per month with \$5 raise every six months for two years; maintenance is available at the hospital for \$40 per month. For further information contact, Superintendent of Nurses, Yuma General Hospital, Yuma, Arizona.

NURSES—Graduate; for new 50-bed general hospital in thriving village, Catskill Mountains, 8-hour day, six-day week, time-and-one-half for overtime after 40 hours, rotating shifts; average gross cash salary \$200 to \$210 month; full maintenance available for \$10.50 week. Apply Superintendent Nurses, Margaretville Hospital, Margaretville, New York. Phone Margaretville 50.

NURSES—Staff; for modern 250-bed general hospital and 75-bed maternity hospital; salary \$225 monthly plus two meals and laundry; increase at 6 month intervals; \$10 additional for evening, nights and maternity duties; \$20 additional for surgery; 40-hour week; housing available at nominal cost. Apply, Superintendent of Nurses, Sutter Hospital, Sacramento, California.

NURSES—General duty; graduate; 57-bed general hospital; university town; private accommodations; new nurses home; pleasant mountain surroundings; state salary expected. Apply, Administrator, Emerald-Hodgson Hospital, Sewanee, Tennessee.

NURSES—General duty staff; for St. Louis Children's Hospital, 500 South Kingshighway Boulevard, St. Louis 10, Missouri; affiliated with Washington University Schools of Medicine and Nursing; many opportunities to graduate nurses desirous of broadening their pediatric nursing background while caring for infants and children with medical and surgical illnesses, contagious diseases and prematurity; rotating shifts; 44-hour week; 2 weeks vacation, 2 weeks sick leave and 4 legal holidays with pay; beginning salary \$205 monthly, no maintenance; \$20 monthly differential for evening and night duty. Apply, Director of Nurses.

(Continued on page 180)

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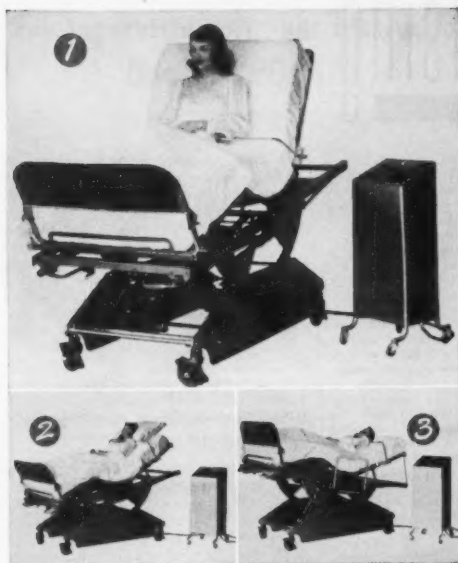
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NURSES—General duty; openings available; opportunities for specialization; 40-hour week; salary \$220-\$260; housing available for a limited period. Apply, Director of Nursing, Columbia-Presbyterian Medical Center, 622 West 168th Street, New York, New York.

NURSES—General duty; for Jersey City Medical Center; positions available immediately; salary \$2160 per year plus full maintenance for experienced nurses in an attractive modern residence; 44-hour week for day duty and 40-hour evening and night duty; 12 national holidays per year; transportation to New York by bus or Hudson Tubes in fifteen to thirty minutes. For complete information write, Director of Nurses, Medical Center, Jersey City, New Jersey.

NURSES—Graduate staff; for modern 250-bed hospital; fully approved; 75 miles from New York City; salary range, \$2400-\$2600; vacation, sick time, holidays with pay; 40-hour week plus overtime; living accommodations available; yearly increment. Apply Administrator, Vassar Brothers Hospital, Poughkeepsie, New York.

NURSES—Medical, surgical, obstetrical, psychiatric, operating room; 325-bed hospital; 40-hour, 5-day week; maintenance available; \$210 per month beginning salary; added pay for nights and relief; increases every six months; well organized staff education program for both recent graduates and experienced nurses. Write, Director of Nurses, The Charles T. Miller Hospital, Saint Paul 2, Minnesota.

NURSES—General duty; 275-bed teaching hospital offers \$240 per month for P.M. duty, \$235 for night duty, \$225 for day duty; salary increases 6, 12, months and thereafter on merit; alternate 5 and 6 day week, average 44 hours; 2 weeks vacation, 12 days sick leave, pension plan; apartments overlooking Lake Michigan for \$32.50 a month, 2 girls to an apartment; meals \$10 each per month; Northwestern University affiliation with special opportunity to take courses at half tuition. Write or apply, Personnel Department, Passavant Memorial Hospital, 303 East Superior, Chicago 11, Illinois.

NURSES—Psychiatric; men and women; for general duty positions open in a psychiatric wing of a 750-bed hospital. Write, Director of Nursing, Buffalo General Hospital, 100 High Street, Buffalo, New York.

NURSES—Registered; for 30-bed general hospital; \$250 per month, 40-hour week, time and a half for overtime. Write, Superintendent of Nurses or Administrator, Blue Mountain General Hospital, Prairie City, Oregon.

NURSES—Registered; 3-11, 11-7 duty; \$200-\$250 per month; \$15 month bonus; uniforms laundered; 5-day week; beautiful suburban area, sports, smart shops; one hour from New York City. Apply Superintendent of Nurses, Overlook Hospital, Summit, New Jersey.

RESIDENCY—Roentgenology; one year; approved. Evangelical Deaconess Hospital, 1821 West Wisconsin Avenue, Milwaukee 3, Wisconsin.

SUPERVISOR—Operating room; for 100-bed general hospital, located in southwest Virginia; excellent working and living conditions; salary open. Apply, Superintendent of Nurses, Pulaski Hospital, Pulaski, Virginia.

SUPERVISOR—Operating room, immediate opening; good location; State Capital with many civic advantages; salary is open. Apply, Director of Nurses, Bismarck Evangelical Hospital, Bismarck, North Dakota.

(Continued on page 182)

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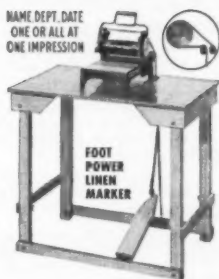
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SUPERVISORS—Night; shifts, 4-12 and 12-8. Apply Superintendent, General Hospital, Parry Sound, Ontario.

SUPERVISORS—Teaching; for modern 250-bed hospital; fully approved, 75 miles from New York City, salary range, \$3000-\$3600; vacation, sick time and holidays with pay; 40-hour week; living accommodations available; yearly increment. Apply Administrator, Vassar Brothers Hospital, Poughkeepsie, New York.

SUPERVISORS—Pediatric supervisor; salary \$250-\$275 per month; Assistant obstetrical supervisor; salary \$230-\$260 per month; Premature nursery supervisor; salary \$230-\$260 per month; applicants with degree and experience preferred; newly expanded 300-bed hospital in college town; facilities include fully equipped class rooms and ward conference rooms; liberal personnel policies including social security. Apply, Director of Nurses, Bronson Methodist Hospital, Kalamazoo, Michigan.

TECHNICIAN—Laboratory; registered; 225-bed general hospital; salary open. Apply, St. Joseph Hospital, Lorain, Ohio.

TECHNICIAN—Laboratory and x-ray combined; 23-bed hospital in a fine community; salary \$250 and commission. Apply President, Community Hospital, Box 47, Lindsay, Kansas.

TECHNICIAN—Laboratory; 185-bed hospital with two laboratory technicians. For full particulars, apply to Superintendent of Nurses, Medicine Hat General Hospital, Medicine Hat, Alberta.

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NURSE ADMINISTRATORS—(a) Small hospital to be completed in October; college town, midwest. (b) 30-year old general hospital, recently moved into new building; excellent facilities; 70 beds; east. (c) Small general hospital, college town, Wisconsin. MH7-2

ANESTHETISTS—(a) New hospital, 250 beds; town 35,000, outskirts university center; minimum \$400 including room or apartment. (b) General, 175-bed hospital; town 25,000, resort area, Pacific northwest; \$400-\$450. (c) General hospital, 300 beds; college town, 70,000, middle west; \$350-\$450. MH7-3

(Continued on page 184)

MEDICAL BUREAU—Continued

ADMINISTRATORS—(a) Medical; fairly large general hospital; voluntary; residential town, metropolitan area; east. (b) Associate medical director; 300-bed general hospital; medical school affiliations. (c) Lay or medical; new 250-bed hospital nucleus of medical center; college town, 100,000, midwest. (d) General hospital; small size; currently under construction; town, 50,000, Pacific northwest. (e) New hospital, 150 beds, affiliated with research institution; winter resort city, south. (f) Small hospital recently completed; resort area, California. (g) Young lay administrator to direct large outpatient department currently under construction; should be qualified to serve as assistant director; large voluntary hospital; east. MH7-1

DIRECTORS OF NURSING—(a) One of the country's most important teaching hospitals; position of great prestige; \$6000-\$8000, maintenance. (b) New hospital, 325 beds; general; medical school affiliations; large city, university center, west. (c) General 200-bed hospital; expansion program; residential section, eastern metropolis. (d) New hospital to be opened for operation in August; collegiate school; college town, northwest. (e) Small hospital and school affiliated with medical school; interesting location; Canada. (f) General hospital, fairly large size; 125 students; all departments well staffed; excellent medical staff; opportunity for continuing studies; near Chicago. (g) Director of nursing service; new six million dollar hospital; teaching affiliations; appointment carries rank professor of nursing. MH7-4

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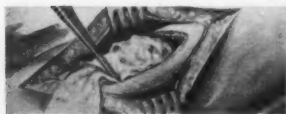
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height beds. Instead of the usual four posts, with all four
posts serving as telescoping members, this new Hill-Rom
bed has but two pedestals, with an improved telescoping
action incorporating the use of a heavy coil spring in the
innertube.

This spring compensates for the weight of the bedspring,
the mattress, and part of the patient's weight, making it
possible for the bed to be raised or lowered faster, with
fewer turns and less effort on the part of the nurse.

This new Hill-Rom high-low bed is a combination of
wood and metal. Structural parts are of steel, with baked-
on enamel finish. The panels are laminated 5-ply Walnut
or Rift Oak. Size, 3' wide x 7'-6" long. Either Hill-Rom's
standard heavy duty Gatch spring, the No. 15 crankless
Trendelenburg or the No. 25 two-crank Trendelenburg
spring may be used.

Patients find it easy
to get in and out of
the Hill-Rom High-
Low bed in the low
position.



Complete particulars on this new Hill-Rom
High-Low Bed will be sent on request.

HILL-ROM COMPANY, INC., BATESVILLE, INDIANA

HILL-ROM
Furniture for the Modern Hospital

classified advertising

POSITIONS OPEN

MEDICAL BUREAU—Continued

EXECUTIVE HOUSEKEEPERS—(a) New hospital, 175 beds; no school; town of 20,000, resort area, Pacific northwest. (b) Beautiful new hospital, 250 beds; residential town; east; \$300, maintenance. MH7-12

EXECUTIVE PERSONNEL—(a) Personnel director; 350-bed teaching hospital; duties consist of general supervision of whole personnel program; university town; midwest. (b) Chief accountant qualified serve as credit manager; 300-bed hospital; southwest. (c) Purchasing agent; fairly large hospital; Pacific coast. MH7-5

FACULTY APPOINTMENTS—(a) Dean, professors, associate and assistant professors, instructors; collegiate program recently established; outstanding candidates only considered; attractive salary schedules and personnel policies. (b) Educational director; collegiate program; rank: full professor; university center; midwest. (c) Director, practical nurse training program; midwest; \$4500. (d) Instructors; operating room, pediatrics, obstetrics; university group; \$300-\$500. (e) Educational director and nursing arts instructor; 300-bed teaching hospital; college town, midwest; opportunity continuing studies; \$4800 and \$4000 respectively. MH7-6

MEDICAL BUREAU—Continued

MALE NURSES—(a) Outpatient department supervisor; large general hospital; midwest. (b) Operating room and night supervisors; small hospital; university town, south. MH7-7

MEDICAL RECORD LIBRARIANS—(a) Chief; new 350-bed hospital; all modern facilities; east. (b) To organize and direct department, group clinic staffed by group of outstanding specialists; \$4200; Pacific coast. (c) Chief; 325-bed hospital; college town, 80,000; middle west; \$5000. MH7-8

PHARMACISTS—(a) New hospital, 100 beds; completion June; college town, south. (b) Ph.D. in Pharmacy, experienced in teaching, qualified to head department; state college; east. MH7-9

STUDENT HEALTH NURSES—(a) College nurse; state college; south. (b) Student health and recreational director; school of nursing; large general hospital; east. MH7-10

SUPERVISORS—(a) Operating room; general hospital, 300 beds; suburb eastern metropolis; \$300, maintenance. (b) EENT supervisor; 20-bed department including surgical suite; large teaching hospital; Pacific coast. (c) Psychiatric; 40-bed unit, medical center; winter resort town, south. (d) Obstetrical; one of leading hospitals, Los Angeles area. (e) Outpatient; new hospital, 200 beds, affiliated 30-man clinic; southwest. (f) Pediatrics, obstetrical and evening supervisors; teaching hospital operated under American auspices in near east. MH7-11

(Continued on page 186)

SHAY MEDICAL AGENCY

Blanche L. Shay, Director
55 East Washington Street
Chicago 2, Illinois

PERSONNEL DIRECTOR—Middle west; 250-bed hospital, fully approved, near Chicago; college graduate with some personnel experience beyond interviewing; duties will include interviewing, general supervision of a complete personnel program; hospital experience not essential; 5½-day week; one month's vacation; this is a wonderful opportunity with a very progressive hospital; \$4000 to start.

ACCOUNTANT—Front office manager; middle west; 125-bed hospital in city of 50,000; fully approved; require a person who meets people well and willing to assume a considerable portion of the accounting plus supervision of a very competent staff of six; \$350 to start with every opportunity for advancement.

DIRECTOR OF NURSES—East; 200-bed hospital, fully approved; now engaged in building program which will increase bed capacity one-third and greatly enlarge other facilities; require B.A. Degree and experience as assistant director; director is also principal of nurses' training school; maintenance is provided in a suite of rooms in their modern nurses' home located one-half block from hospital on a quiet residential street; this is a splendid opportunity in a hospital which is just starting its growth to meet the challenge of a greatly expanded residential and industrial community; \$4200-\$6000.

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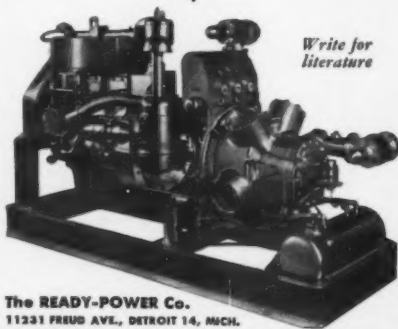
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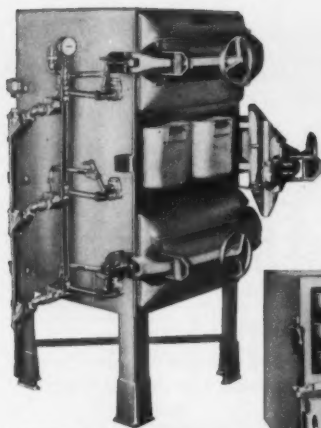
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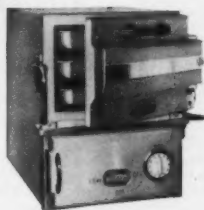
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(Below) one compartment CUB Steamcraft counter model. Also made in two compartment size. Either size furnished for direct steam, or for gas or electric operation. Indicating timer or fully automatic controls optional.



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You save time—cooking starts at once, without waiting for water to boil. You avoid waste—food can be quickly prepared in small or large amounts. You save labor, especially in the handling and cleaning of so many pots and pans. Besides, food is never scorched in a steamer.

Better flavor is assured by steaming, as natural food flavors are not dissolved or cooked out. Shrinkage is largely avoided by the relatively low temperature of steaming. As there is no agitation of boiling water to destroy the food structure, and there is a moist heat rather than a parching heat, food texture is better maintained. Natural color, especially of vegetables, is preserved, and foods are more attractive in appearance.

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Steam-Chef standard models come in sizes from 1 to 4 compartments. Steamcraft Junior cookers and warmers are furnished with 1 or 2 compartments (holding standard cafeteria pans) with base or for counter use. Indicating timer or fully automatic controls. Any of our steamers can be furnished for operation on direct steam line, or electricity, or any gas.

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Overall—
Width 28"
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Height 30"
Also without
arms



low back chair 3406

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Depth 29"
Height 29"
Also without
arms



high back chair 3407

Overall—
Width 28½"
Depth 30½"
Height 42"
Also without
arms



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POSITIONS OPEN

SHAY—Continued

DIETITIAN—South; 425-bed university hospital; fully approved; duties all administrative; school of nursing is maintained; hospital is located in a city of 750,000 in a lovely residential district within easy walking distance of downtown business section; \$375.

INTERSTATE HOSPITAL AND PERSONNEL BUREAU

Miss Elsie Day, Director
332 Bulkley Building
Cleveland, Ohio

ADMINISTRATORS—(a) 100-bed hospital; private; mid-western university city. (b) 75-bed hospital; Kentucky; new wing under construction. (c) 50-bed hospital-clinic; north-west; part-time business manager considered. (d) 40-bed new hospital, southeastern resort city.

BUSINESS MANAGER—Large well-known hospital; medical school affiliation; 3 years experience required.

INTERSTATE—Continued

NURSE SUPERINTENDENTS—(a) 45-bed hospital; Florida. (b) 50-bed hospital; Indiana. (c) New hospitals now under construction in mid-western states. (d) 55-bed hospital; New England.

PERSONNEL DIRECTOR—200-bed Ohio hospital.

DIRECTORS OF NURSING—(a) 150-bed hospital; Pennsylvania. (b) Modern childrens hospital; medical school affiliation; \$5,000. (c) 325-bed hospital, suburb New York. (d) 150-bed hospital, Florida. (e) 200-bed hospital; college town; mid-west.

DIRECTORS OF NURSING SERVICE—(a) New modern hospital; southern city; practical nurse program. (b) 210-bed western hospital; \$4500, maintenance. (c) Assistant; 300-bed Ohio hospital; \$4350.

DIRECTORS, NURSING EDUCATION—(a) 250-bed hospital; Ohio. (b) Nursing arts instructors; \$350. (c) Clinical instructors; \$275-\$300.

CHIEF RECORD LIBRARIANS—(a) 250-bed hospital; mid-western medical center; \$350. (b) 300-bed hospital; near New York.

X-RAY TECHNICIANS—(a) Chief; 300-bed sisters' hospital; Ohio; \$350. (b) 100-bed hospital, Pennsylvania; \$200, maintenance.

(Continued on page 188)

INTERSTATE—Continued

TECHNICIANS—(a) To supervise blood bank; \$285. (b) Laboratory and x-ray; small hospitals; \$225; maintenance.

PHARMACISTS—(a) \$325. (b) Physiotherapists; \$4,000. (c) Occupational therapists; \$4200.

DIETITIANS—(a) Chief; 275-bed hospital; Connecticut. (b) 300-bed Ohio hospital; \$350, maintenance. (c) 400-bed tuberculosis sanatorium; \$350.

BUSINESS AND MEDICAL REGISTRY (Agency)

Elsie Miller, Director
610 South Broadway, Room 1105
Los Angeles 14, California

ANESTHETIST—Clinic hospital of 100 beds, north central California; \$375; 40-hour week.

DIRECTOR OF NURSES—Some administrative duties included; new district hospital not far from Los Angeles; capacity 35 beds; \$325; 40-hour week.

ASSISTANT DIRECTOR OF NURSING—Private general hospital of 250 beds, 75 students, San Francisco area; degree and administrative experience required; excellent salary.

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Serve meals that are consistently flavorful and you'll please your patients as well as lower operation costs by eliminating unnecessary waste. Today hundreds of institutions are depending upon economical Maggi's Granulated Bouillon Cubes to bring new appetizing goodness to their soups, stews, gravies and many other dishes that call for meat stock.

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This is a TENSOR elastic bandage with the cotton threads cut away to show the live rubber threads that give it true elasticity.

No rubberless elastic bandage can do what *TENSOR* does. It is genuinely elastic, because of its *live rubber* threads. Actually stretches to more than twice its length.

TENSOR'S lively stretch makes possible a wide range of pressures—always under firm control. Easy to apply—stays in place. Frequent adjustments are not needed. Elasticity remains indefinitely—even after repeated laundering. Cool, lightweight, inconspicuous. A comfort to the patient—a convenience to the doctor.

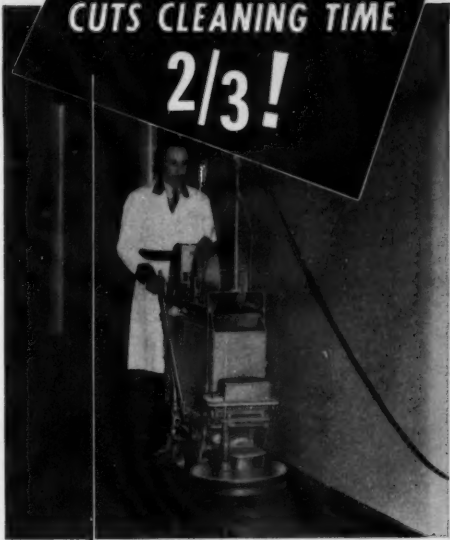
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2/3!



For Small-Area Buildings

- Specially designed for buildings with 2,000 to 15,000 sq. ft. of floor space
- Applies the cleanser, scrubs, rinses if required, and picks up in ONE operation (vacuum performs quietly)
- Handles BOTH wet and dry work
- Self-propelled
- Can be leased or purchased

Now the labor-saving advantages of combination-machine-scrubbing are available to small as well as larger buildings. The new 418P Finnell Scrubber-Vac cleans floors in approximately one-third the time required with a conventional 15 or 18-inch polisher-scrubber using separate equipment for picking up. A Finnell Scrubber-Vac speeds cleaning by handling four operations in one! It applies the cleanser, scrubs, rinses, and picks up (damp-dries the floor)—all in a single operation.

The new 418P Scrubber-Vac can be used for the dry work (polishing, et cetera) as well as the scrubbing. And all the refinements of Finnell's larger combination machines are embodied in this smaller unit. Has 18-inch brush ring.

SEE IT IN ACTION ON YOUR OWN FLOORS!

Find out what you would save with a Finnell Scrubber-Vac. Finnell makes several models and sizes. For demonstration, consultation, or literature, phone or write nearest Finnell Branch or Finnell System, Inc., 1407 East Street, Elkhart, Indiana. Branch Offices in all principal cities of the United States and Canada.

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POSITIONS OPEN

BUSINESS & MEDICAL REGISTRY— Continued

NIGHT SUPERVISOR—Charge of house; 100-bed Catholic hospital, city of 75,000 north-east of Los Angeles; \$280.

OBSTETRICAL SUPERVISOR—Assistant to director of small and well established maternity hospital, southern California city; \$285; excellent connection and opportunity for future.

PHYSIOTHERAPY TECHNICIAN—Registered; county hospital, 300 beds; central California; \$350.

SENIOR LABORATORY TECHNICIAN—Experienced in bacteriology and parasitology; \$300-\$350 plus overtime for call above 40-hour week; 100-bed California hospital near one of the most picturesque spots on the California coast.

MEDICAL PERSONNEL EXCHANGE

Nellie A. Gealt, R.N., Director
4707 Springfield Avenue
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CLINICAL DIRECTOR—Certified or eligible, American Board of Psychiatry; modern 2500 mental hospital; salary open; maintenance includes modern well furnished 8-room house.

MEDICAL PERSONNEL EXCHANGE— Continued

NURSE ANESTHETIST—165-bed southern hospital, to \$500 monthly.

DIRECTOR OF NURSING—250-bed hospital to \$600, plus maintenance.

DIETITIAN—Chief; well organized department; \$350, maintenance.

INSTRUCTORS—(a) Science; (b) Nursing arts 275-bed hospital, Pennsylvania; to \$360.

SUPERVISOR—Operating room; 150-bed hospital, \$225, P.M.

SCRUB NURSE—90-bed hospital; Pennsylvania; \$300.

REGISTERED RECORD LIBRARIAN—Head; 190-bed children's hospital, salary open.

PHYSICAL THERAPISTS—(2); large general hospital; \$300 and full maintenance; recent graduates acceptable, will be given time off to take examination for registration.

MEDICAL SOCIAL SERVICE WORKER—Head; M.A. Degree and hospital experience required; \$3600.

No charge for registration.

(Continued on page 190)



OUR 55th YEAR
WOODWARD
Medical Personnel Bureau
FORMERLY AXNOR'S
3rd floor—185 N. WABASH AVE.
CHICAGO • I
• ANN WOODWARD • Director

ADMINISTRATIVE PERSONNEL—(1) Purchasing agent; 100-bed California hospital; may make reasonable investment; excellent for permanent security. (m) Personnel director; 250-bed New England general voluntary hospital; desirable summer resort, college town \$5,000. (n) Accountant; full charge; 85-bed general voluntary hospital; must be qualified to succeed present assistant administrator; college town 15,000; midwest. (o) Office manager and administrative assistant; 100-bed hospital; excellent town 25,000 midwest.

ADMINISTRATORS—Nurses. (a) Anesthetist, superintendent, new 80-bed hospital; Virginia mountain resort area. (b) 50-bed college community hospital; northwest. (c) 100-bed New York hospital; excellent opportunity. (d) New 30-bed hospital, New York summer resort area. (e) Modern, 100-bed hospital, vicinity southern state capital. (f) 90-bed well staffed general hospital; building program under way; midwest. (g) 30-bed, Iowa, general hospital; erected in 1950; \$4200 up. (h) Small, Texas hospital now under construction.

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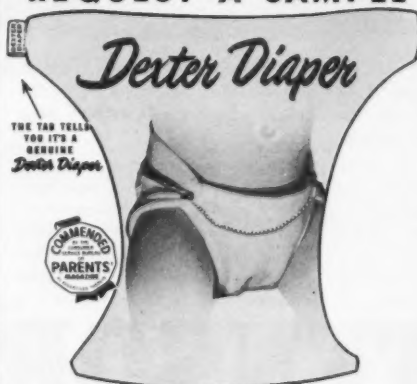
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RIGHT... AND QUICK
BE SURE THAT
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Top-kicks in mop sticks! Yes, these handsome, hard-working WHITE mop sticks are the acknowledged leaders in the field. They never shirk the toughest duty — stay on your job years longer. See WHITE mop sticks at your jobber's — put them to work for you!

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No. 937 — Steel Handle
A heavy duty mop stick for hospitals, hotels, etc. — yet light enough for easy handling. No slivers... sanitary... longer lasting. Screw type head.

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Malleable iron 7" head on a sturdy 1 1/8" hardwood handle. Free from slivers. Rust-proof finish. Change mop easily in a few seconds.

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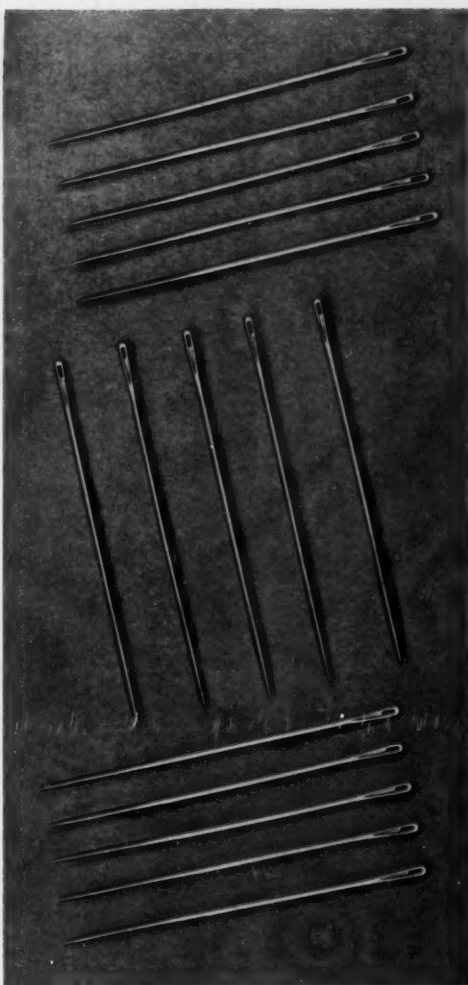
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POSITIONS OPEN

WOODWARD—Continued

ADMINISTRATORS—(a) Lay or medical; 300-bed general voluntary hospital; highly desirable college town 45,000; requires member, ACHA; east. (b) Lay; 200-bed general hospital, starting new wing; resort town 40,000; east. (c) Lay; 300-bed general voluntary hospital; requires member, ACHA; very desirable southern metropolis. (d) Lay; 250-bed, brand new hospital opening late 1951; university, resort city of west. (e) Lay; highly qualified to supervise 7 hospitals located various Pacific Islands; large amount travel; also administrator for each hospital. (f) Lay; brand new 100-bed county community hospital; requires one able to open hospital; town 25,000; south. (g) Lay; assistant; must be qualified to succeed present administrator in short time; degree and hospital residency essential; planning to relocate hospital in 14 acre, 200-bed building soon; large university city; highly recommended. (h) Lay; 100-bed general hospital; large university and college city; east. (i) Lay; 100-bed west coast hospital; may make reasonable investment; larger than average income; excellent for permanent security. (j) Lay; 75-bed general hospital now adding new wing; town 15,000; north. (k) Lay; 50-bed general hospital now adding new wing; college town; Pacific northwest.

WOODWARD—Continued

ANESTHETISTS—(a) Well established clinic, five surgeons, four anesthetists on staff; mid-west college town; salary to \$500. (b) Large, approved hospital, midwest capital city; \$5000 yearly. (c) 150-bed approved hospital, south-eastern Pennsylvania; \$4500 maintenance. (e) 100-bed approved hospital, good location Pacific northwest; \$4200 yearly.

DIETITIANS—(a) Chief, medium-sized general hospital, Pacific resort area, northern California; \$4000 yearly. (b) Assistant; 200-bed hospital university town vicinity Philadelphia; \$3600 minimum. (c) Chief; 100-bed fully approved hospital; sea-coast resort southern Florida; \$3600 minimum. (d) Therapeutic; large university hospital, good location, eastern capital; \$4200.

DIRECTORS OF NURSING—(a) 140-bed southern hospital; \$400 maintenance. (b) Small hospital, graduate staff, vicinity southern capital; \$400 up. (c) 100-bed California, vicinity coastal resorts; \$4000 maintenance. (d) 100-bed hospital, eastern state capital; \$5000 maintenance. (e) 100-bed hospital Hawaiian territorial capital; \$4500. (f) Small tuberculosis hospital, vicinity exclusive suburban communities near Chicago; \$4500 minimum.

WOODWARD—Continued

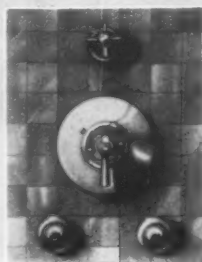
HOUSEKEEPERS—(a) Large, tuberculosis hospital, university medical center, midwest state capital; \$3600. (b) 100-bed approved New York hospital; \$200 maintenance. (c) 250-bed Texas hospital; must be thoroughly trained all phases; excellent salary.

FACULTY APPOINTMENTS—(a) Nursing arts instructor, southern university hospital; \$4000 up. (b) Science; 250-bed Illinois hospital; \$3600 maintenance. (c) Psychiatric, large eastern state hospital; \$3300 up. (d) Clinical, general, 400-bed eastern hospital; \$3750.

OPERATING ROOM SUPERVISORS—(a) Fully approved, 200-bed California hospital, Frisco vicinity; \$4000 minimum. (b) 200-bed approved hospital, unusually prosperous community adjacent Chicago; \$4200 yearly. (c) 100-bed New York hospital, very modern operating unit; to \$3600. (d) 100-bed approved hospital, New York university town; \$3600 up. (e) Faculty appointment, southern university hospital; \$5000.

PHARMACISTS—(a) 50-bed, well established clinic, hospital, excellent location Lake Michigan resort community; \$5200 up. (b) 100-bed California hospital, unique financial opportunity. (c) 100-bed hospital, city 15,000, adjacent state capital; \$4800.

(Continued on page 192)



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meal salads Pear side salads Pear desserts

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WASHINGTON

Bartlett Pears



classified advertising

WOODWARD—Continued

RECORD LIBRARIANS—(a) Large tuberculosis hospital, Chicago, area; \$4800. (b) Western university medical center, city 100,000; \$4200 up. (c) 150-bed approved Michigan hospital, lake resort area; \$3600 minimum. (d) 250-bed hospital, city 50,000, vicinity New York; \$4200 yearly. (e) 400-bed hospital, southern medical center; must be qualified to take full charge. (f) 200-bed approved hospital, Ohio college town; salary to \$5000 yearly. (g) Southern university hospital; full charge, salary to \$4200.

SUPERVISORS—(a) Clinical: 400-bed approved general hospital, 200 students, vicinity Cincinnati; \$3600. (b) Obstetrical: 1250-bed general hospital recently constructed, central Washington; \$3750. (c) Surgical: medium-sized teaching hospital, 40-hour week, Michigan resort locality. (d) Psychiatric: faculty appointment 500-bed approved hospital western New York; \$3600 up. (f) Operating Room: 200-bed general hospital San Francisco area; \$3600 up.

TECHNOLOGISTS—(a) Qualified to supervise department, large teaching hospital, midwest state capital; Master's Degree required; salary \$4800 yearly. (b) Qualified in bacteriology for health department Chicago area; \$3900. (c) Histology: large teaching hospital Colorado Rocky Mountain location. (d) X-ray; small approved Texas hospital; \$4200 maintenance. (e) Laboratory and x-ray; well established active clinic, Wisconsin resort city; \$3600.

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(Continued on page 194)

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Write for information to Building Materials Department
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Vol. 77, No. 1, July 1951

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GRADUATE HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA offers a four months' course in Operating Room Technique and Management to registered graduates of accredited schools of nursing. Apply to Director of Nursing, 1818 Lombard Street, Philadelphia 46, Pennsylvania.

The **PROVIDENCE LYING-IN HOSPITAL** offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and a stipend of \$60 a month is provided. For full information, apply to the Director of Nurses, Providence Lying-In Hospital, Providence 8, Rhode Island.

JERSEY CITY MEDICAL CENTER SCHOOL OF NURSING offers to qualified graduate nurses a four-month course in operating room technique. Full maintenance and stipend granted. Apply to Director of Nurses, Jersey City Medical Center, Jersey City, N. J.

SCHOOL FOR LABORATORY TECHNICIANS—Duration of course, 1 year. Tuition, \$100.00; approved by the American Medical Association. For further information, write the Director of Laboratories, Barnes Hospital, 609 S. Kingshighway, St. Louis, Mo.

The **CHICAGO LYING-IN HOSPITAL** and **DISPENSARY** of the **UNIVERSITY OF CHICAGO** offers a six months' course in obstetric nursing to qualified graduate nurses. The course includes all phases of maternity nursing. The student may elect experience in one special area for two months of the course. Modern, attractively appointed kitchenette apartments are provided. Adequate allowance is made for food and laundry. For further information, write to the Director of Nursing, 5841 Maryland Avenue, Chicago 37, Illinois.

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Programs for 1951-1952
Leading to the degree of Bachelor of Science in Nursing:

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 - Medical-Surgical Nursing
 - Mother-Infant Care
 - Operating Room Technique
 - Pediatric Nursing
 - Psychiatric Nursing

For further information write to the Director, Washington University School of Nursing, 416 South Kingshighway, St. Louis 10, Missouri.

The **MARGARET HAGUE MATERNITY HOSPITAL**. The largest hospital in the country offers the following to registered, professional nurses of accredited schools:

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Following the above program, a two months' course is offered to students who have demonstrated potentialities for head nurse responsibilities. It includes instruction in principles and methods used in clinical teaching program and ward management. Students plan and conduct their program of clinical instruction with the head nurse and serve as assistants. They are directed and supervised by the instructor of the course.

Classes admitted every other month beginning February. Maintenance and stipend of \$75.00 per month granted. Write for catalogue. Address Rose A. Coyle, R.N., Director of Nurses, 88 Clifton Place, Jersey City 4, New Jersey.

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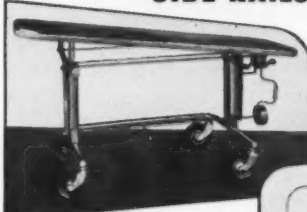


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It's the new TOLAND Overbed Stretcher!

Two new features make the Toland Stretcher even more versatile than before: (1) You can now obtain the Toland Stretcher designed for Trendelenburg Position—and it's easy to set, too! Just lift the stretcher top, and the support arms slip into place—that's all! No fussing with pins or bolts, no danger of slipping, or jarring the patient. (2) Side Rails are now obtainable, making the Toland Stretcher ideal for post-operative use. Easily detached, and carried under the Stretcher.

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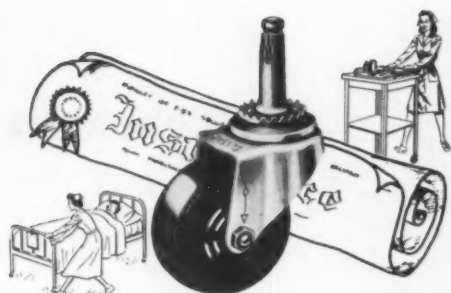
YOU CAN HELP PREVENT the spread of disease germs from Formula Room to Nursery by making Terminal Sterilization standard procedure in the preparation of infant formula. This newer, safer method produces and maintains bacteriologically safe formula . . . eliminates the Formula Room as a source of infection. For up-to-date information about Terminal Sterilization and how it can work for you . . . *write to Pet Milk Company, 1486-G Arcade Building, St. Louis 1, Missouri.*

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THE NATION'S HEALTH**



Pet Milk Laboratories conducted original research that played a vital part in the development of this newer, safer technique.

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Here's the best way to insure your hospital against floor damage.

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WITHOUT A SINGLE STITCH!**

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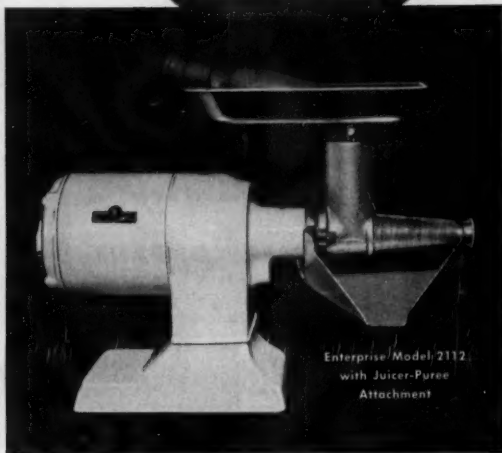
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When You Get it From



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Smooth Lines



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With ten choppers to choose from in the balanced U. S. line you can be sure of getting the one that's fitted to your own needs. The $1\frac{1}{2}$ H. P. Model 2632 chopper combines high capacity with smooth, easy-to-clean design. All these choppers are precision-made to cut cleanly without mashing or heating the meat. Model 2112 with $\frac{1}{2}$ H. P. motor is *right* for the smaller establishment or as a second machine.

When equipped with Juicer-Puree attachment at slight extra cost the 2112 chopper makes it easy to prepare tomato juice, apple sauce, puree of sweet

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BLOOD
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These Lifetime Stainless Steel Refrigerators are designed for really rugged service, year after year, for complete sanitation, easy cleaning and many other plus features.

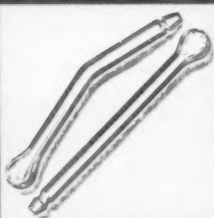
Meets the specific needs for all hospitals, because of such features as separate removable trays, permitting necessary segregation, easy and quick handling, classification and labelling.

Completely self-contained units; require no special installation, just uncrate and plug into electric circuit. Made in several sizes to fit your requirements . . . also can be used in Pharmacy or Diet Kitchen.

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This acquisition was due to a fire on February 13 of this year which completely destroyed the plant of the Schwartz Sectional System, Inc., in Indianapolis.

It permits us to present all the features of the Schwartz Sectional System combined with those of the Grand Rapids Sectional System, together with our modern construction methods, enabling us to produce the finest in prescription room equipment.

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STORE EQUIPMENT COMPANY
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**Patient comfort
is prompt**



Prompt, continued control of pain is one reason its "FOILLE First in First Aid" in treatment of BURNS, MINOR WOUNDS, LACERATIONS, ABRASIONS in offices clinics, hospitals.

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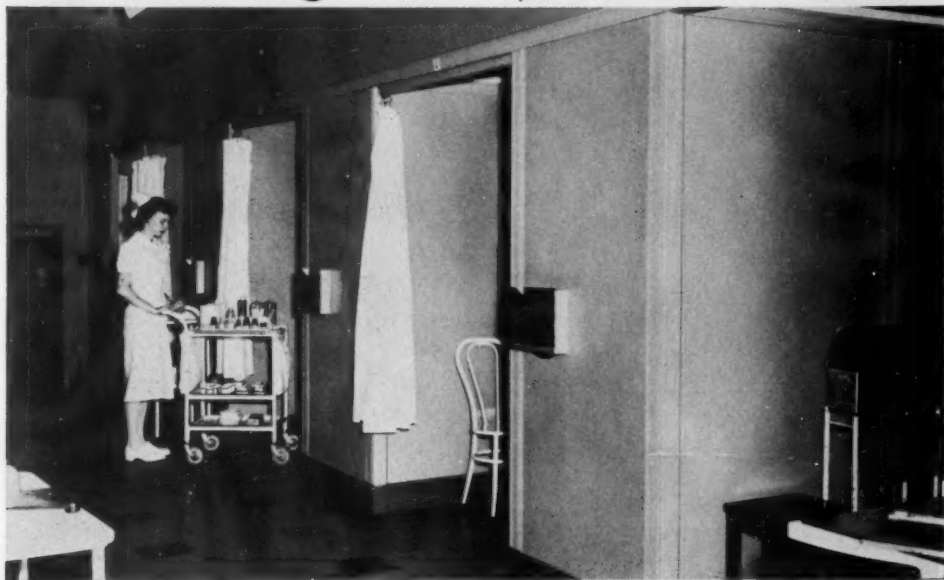
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● There's a neat, confidence-inspiring appearance which is distinctive in Hauserman *Movable Steel Partitions* for hospitals. These characteristically *clean*, characteristically *easy to move* steel walls are utilized profitably by public, private and company hospitals alike. The photo above shows the Hauserman installation in the Temple University Hospital, Philadelphia, Pa. Hauserman *Movable Steel Interiors* are solid, rigid walls, with baked-on finishes that won't develop unsightly, unsanitary cracking, chipping, scaling or blistering. These durable, beautiful finishes can be washed year after year . . . with normal soap and water solutions . . . without changing their original colors or coverage. Any unit in a Hauserman Steel Interior installation can be moved easily and quickly when new floor layouts are desirable.

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• The almost universal preference for Visionaire Canopies by hospital nursing staffs is not accidental. Continental Visionaire Canopies have full length skirts, 60" long, to stay "tucked in." All seams are electronically welded, high oxygen concentrations have no effect on their stability. They can be supplied with

zipper or folding sleeve closures as desired.

Made from transparent plastic that gives the patient full room vision and that allows the nurse to see the patient always. They're inexpensive. Continental is the world's largest manufacturers of oxygen tent canopies. Write for full details about Visionaire Canopies.

CONTINENTAL HOSPITAL SERVICE, Inc. • 18636 Detroit Ave. • Cleveland 7, Ohio



Today you just can't cover it!

In these days of rising construction costs and scarce materials you face a double threat against which insurance simply cannot protect you.



If your hospital should burn, you will almost certainly find that your insurance indemnity check is inadequate to cover replacement. You will find that you are harried by costly delays in replacing scarce equipment, while your employees drift to other jobs. Fortunately, there is one way to protect your hospital against ruinous fire losses in times like these. That is the positive protection of an automatic sprinkler system.

Needless loss of property and life can be prevented by checking fire at its source, whenever and wherever



it starts, automatically, with a Grinnell Automatic Sprinkler System. Seventy years experience proves this.

In hospitals, moreover, there is a moral obligation upon management for the utmost in protection of life and property. So for your own sake, be sure the lives for which you are responsible are protected with Grinnell automatic sprinkler heads—your assurance of positive, automatic fire protection.

Grinnell Company, Inc., Providence 1, R. I.



GRINNELL
FIRE PROTECTION SYSTEMS

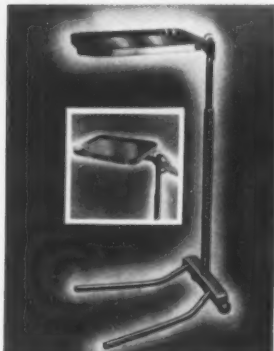
What's New for Hospitals

JULY 1951

Edited by BESSIE COVERT

TO HELP YOU get information quickly on new products described in this section, we have provided the convenient Readers' Service Form on page 220. Check the numbers of interest to you and mail the coupon to the address given on the form. If you wish other product information, just list the items and we shall make every effort to supply it.

Mayo Instrument Stand



Easy one-hand control and complete stability are features of the newly designed Manhattan Model Mayo Instrument Stand. Made entirely of 18-8 grade stainless steel, it has all welded construction. An internal, non-slip device locks the tray at any height automatically. A finger-tip control button lowers the stand easily and smoothly and it locks automatically when button is released.

The base of the stand consists of a crosswise stainless steel channel mounted on ball-bearing, electrically conductive swivel rubber casters. The stand is adjustable from 39½ to 62 inches in height and the removable stainless steel tray rests in a seamless stainless steel tray frame. The weighted base, with extra long extensions, is especially designed to slide under the operating table. S. Blickman, Inc., Dept. MH, Weehawken, N.J. (Key No. 372)

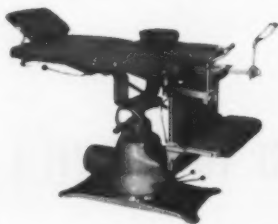
"Low Sodium" Canned Meats

After extensive experimentation, Armour and Company Research Laboratories have developed a method of reducing the sodium content of meat, thus making it available for use in special diets for hypertension, coronary complications, pregnancy, kidney diseases and other conditions requiring low sodium diets. The new Armour meat products will be put up in 5½ ounce cans for

single servings. They will contain only 30 to 50 milligrams of sodium per 100 grams of food. The label on each can will state the sodium content for easy calculation of the total sodium intake.

The first products to be made available in the new line will be beef stew, beef hash, beef and gravy, chili con carne, meat loaf and meat sauce. No salt, salt substitutes or chemicals are used in any phase of the preparation of these foods and only standard spices and vegetable flavorings are employed in the recipes. Armour will prepare and pack the meat under U.S. Inspection for the Hilsom Corporation which will handle national distribution under the Hilsom name as a special dietetic pack. The Hilsom Corporation, Dept. MH, 4 W. 58th St., New York 19. (Key No. 373)

Multi-Purpose Table



The Ritter Universal Table, Type "2," is one of a completely new line of motor-elevated multi-purpose tables. It is a flexible three section model with headrest and knee rest easily adjustable to any required position. Perineal cut-out, stainless steel irrigation pan, stirrups and handwheel-operated tilt mechanism are included as standard equipment. The table is 80 inches in length with headrest and knee rest extended. It has an elevation range from 26½ to 44½ inches, is 23 inches wide, tilts to a 45 degree angle and has rotation of 180 degrees. The table can be supplied with explosion-proof base for maximum safety.

The Universal is carefully constructed for ease of operation, patient comfort and attractive appearance. As with all models in the new line, the table is

cushioned with sponge rubber and covered with moisture and stain proof vinyl coated nylon fabric. All adjustments are positive-locking, within easy reach of hand or foot.

The design of the heavy, sturdy base prevents accidental tilting and the motor-driven hydraulic operation lowers the table to provide easy access, then raises it silently and smoothly to convenient examination or treatment height. A foot pump base can be provided if preferred. The Ritter Company, Inc., Dept. MH, Rochester 3, N.Y. (Key No. 374)

Curtis Dua-Lite

A newly designed incandescent unit has been introduced as the Curtis Dua-Lite. It provides indirect illumination for general room lighting as well as direct illumination over the bed as a reading light. A glass cover, together with an efficient alzak aluminum reflector, softly diffuses the indirect light throughout the room. A Fresnel lens is utilized to control distribution of the 75 watt lamp used in the direct component.

The Dua-Lite has outlet plug built into the bottom of each unit for the convenience of doctors, nurses or patients in plugging in instruments, radios and other electrically powered equipment. The housing of the lamp is cast aluminum which can be easily painted after installation to harmonize with the



room interior. Curtis Lighting, Inc., Dept. MH, 6135 W. 65th St., Chicago 38. (Key No. 375)

Advanced Design!

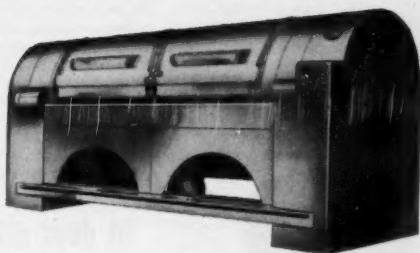
**FOR HIGHER
PRODUCTION
PER SQUARE FOOT**

**FOR LOWER
COST PER
POUND PROCESSED**

Hoffman Monel Metal "Unloading" and "Standard" Washers

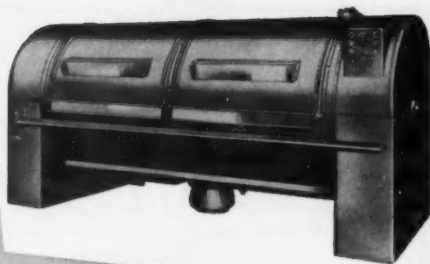
THE "UNLOADING"

Provides more rounds per day by cutting down time formerly needed to "pull" loads. Hydraulic mechanism raises cylinder and shell. Work is deposited into trucks or into basket halves of an unloading extractor. Releases labor for other operations and avoids wear and tear on loads. Single-end drive. Monel metal construction.



THE "STANDARD"

Furnished with open-pocket or horizontal partition. Latter type facilitates "No-Lift" unloading since horizontal partition lines up level with shell door opening. All standard cylinder sizes. Monel metal construction.



YOUR CHOICE OF WASH CYCLE CONTROLS available on "Unloading" and "Standard" Washers. Fully automatic, with central or individual supply stands. Or, semi-automatic with air-actuated control of each operation, once supplies are added.

Modernize Now! Ask your Hoffman Representative About Our Complete Line of Laundry Equipment



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U. S. HOFFMAN MACHINERY CORP. 105 FOURTH AVENUE, NEW YORK 3, N. Y.

Combination Cabinet and Table



A new combination overbed table and somnue has been introduced by American Hospital Supply Corporation to serve as a complete bedside unit. It is designed to be used on either side of the hospital bed. The unit provides an adjustable overbed table with a bedside cabinet or somnue. In addition, it has two electric outlets, two shelves and a fully adjustable reading lamp. Brackets within the somnue hold a bedpan, wash basin, urinal and extra space for storing other supplies and equipment.

The new unit was the subject of a contest to select a suitable name. First prize was won by Mary M. Murdock,

Secretary in the Nursing Office of the U. S. Marine Hospital, Brooklyn, New York, when she suggested the name "Nightingale." American Hospital Supply Corp., Dept. MH, Evanston, Ill. (Key No. 376)

Electronic Control

A new electronic control has been announced for engineered steam heating systems. All control panels for Dunham systems are now equipped with the RST-EA-A Electronic Amplifier. The amplifier indicates and controls temperature changes and replaces a galvanometer as nerve center for the panel. C. A. Dunham Co., Dept. MH, 400 W. Madison St., Chicago 6. (Key No. 377)

Chair That Folds

An attractive upholstered Chair That Folds is now available with a convenient handhold at the top. This speeds up handling where chairs are moved and handled rapidly, whether folded or unfolded. The handhold is at the top of the back where it can be readily grasped without stooping or fumbling.

The chair is attractive in appearance and comfortable in use. The cushions are made of rubberized hair, upholstered in leatherette in a full range of colors.

The new handhold feature does not interfere with comfort or appearance. The chair folds flat, the upholstered portions folding in against each other for full protection in storage and moving. The folding hinge and brace which fastens the two leg units and the seat frame together strengthen the chairs for any use. There is no wear on the upholstery or the wood parts of the chair as folding takes place within the hinge mechanism itself. The chairs are built of hardwood and are available in several



finishes. Louis Rastetter & Sons Co., Dept. MH, Fort Wayne 1, Ind. (Key No. 378)



"...our business took a decided turn for the better
30 days after we began using Accent."

writes J. E. C. DAVIS
of the Pine Tree Inn,
Lynn-Haven, Virginia



In Ac'cent, we're sure we have a wonderful product that does wonderful things for the flavor of nearly every food. But no words of ours could be as convincing to you as this letter:

"We are enthusiastic users of Ac'cent and have incorporated this taste intensifier in almost all of our standard recipes. These recipes include soups, sauces, stews, and dressings. We also use Ac'cent with salt and butter as a steak sauce. Mixed with salt in the ratio 5 parts salt and 1 part Ac'cent, we find that your product greatly enhances the flavor of fried chicken and shrimp prepared for cocktails.

"We think it is more than coincidence that our business took a decided turn for the better 30 days after we began using Ac'cent, at about the time Ac'cent was introduced in Institutions Magazine. This was at a time when the Retail Trade

Reports showed that restaurant business in this area was on the decline. Naturally we are enthusiastic about Ac'cent."

Sincerely yours,

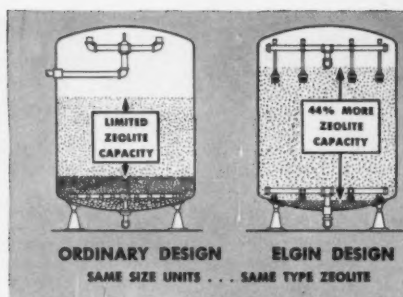
(signed) J. E. C. Davis, Pres., Davis Bros. Corp.

Pretty substantial proof, isn't it? Start using Ac'cent today . . . At every station in your kitchen. AMINO PRODUCTS Division of International Minerals & Chemical Corp., 20 N. Wacker Drive, Chicago 6, Ill.

Ac'cent®
PURE MONOSODIUM GLUTAMATE

...makes
good cooking
taste better





Up to 44%
More Soft Water
FROM SAME SIZE SOFTENER
USING SAME TYPE ZEOLITE

Does it sound too good to be true?

Perhaps it does, but thousands of ELGIN "Double-Check" installations say it's so!

Two ways to cut softener costs with the "Double-Check" principle

One way is to install an Elgin "Double-Check" Softener — or you can have the "Double-Check" manifold equipment applied to your present softener — *any make*.

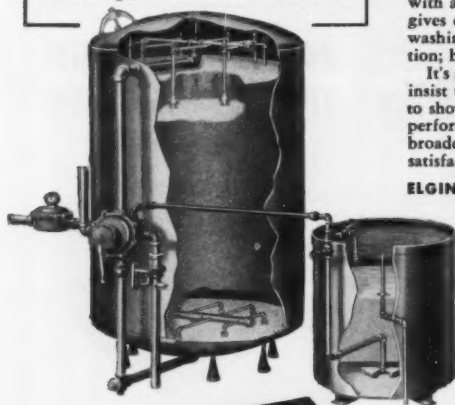
Our District Engineer will be glad to show you how your present water softener can be modernized. Many softeners equipped with the "Double-Check" manifold and Elgin high capacity zeolites are delivering 3 to 10 times more soft water.

Far more soft water from a softener costing no more to buy, and less to operate, *does* sound "too good to be true." Many operating men have felt that way about it, but when all the cards were down the net result in most cases was the purchase of an Elgin "Double-Check" Softener . . . or the installation of "Double-Check" equipment to modernize and step up the capacity of their present water softeners.

We would like to have you ask us to prove our case. Meantime, glance for a moment at the diagrams above which point out the big basic improvement in Elgin design. The important point is that a softener employing conventional manifolds is constrained to a shallow zeolite bed and a slow back-wash rate to prevent the escape of zeolite. This handicap is removed by the ingenious and exclusive Elgin "Double-Check" manifolds which prevent escape of zeolite even with a deep zeolite bed and a high back-wash rate. The extra zeolite gives extra water softening capacity of course, and the higher back-washing rate means better cleansing of the zeolite; thorough regeneration; higher efficiency.

It's as simple as that, but we repeat that we would like to have you insist that we prove our case in terms of your plant. We would like to show you that the Elgin "Double-Check" offers not only more in performance, but also more in quality. We also want to explain our broader servicing program that assures peak performance and lasting satisfaction. Coupon brings all the facts.

ELGIN SOFTENER CORPORATION, 144 N. Grove St., Elgin, Ill.



NEW ZEOLITE
will put new life in
your water softener



All types of zeolites furnished.
Write for information on type needed.



Please send bulletin giving information about:

- ☐ Elgin Water Softener ☐ Zeolites
☐ Modernizing our water softener

Name

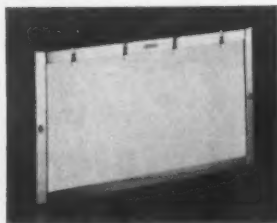
Company

Address

Mail to Elgin Softener Corp., 144 North Grove Street, Elgin, Illinois

SOFTENERS • CHEMICAL TREATMENT • FILTERS • BOILER WATER CONDITIONING

Fluorescent Illuminator



A new fluorescent, double illuminator has been introduced for reading two 14 by 17 inch x-ray films or viewing any transparencies up to 17 by 28 inches. Two switches control four 15-watt fluorescent daylight lamps, two lamps on each switch. The illuminator may be recessed in the wall or placed on a desk when supported by two braces. Four adjustable tension type clips permit wet film viewing. The frame is of 18 gauge monel metal, satin finished. **Picker X-Ray Corp., Dept. MH, 300 Fourth Ave., New York 10.** (Key No. 379)

B-D Plastic Tubing

A special vinyl compound plastic tubing for continuous or intermittent

parenteral anesthesia or medication has been introduced by Becton, Dickinson and Company after five years of research. Described as non-toxic, dimensionally stable and sterilizable by boiling or autoclaving, B-D Plastic Tubing is introduced into the body through special thin-wall soldered hub needles which are then withdrawn, leaving the tubing in place as long as desired. This eliminates the need for successive punctures as well as the danger of damage to the venous, subarachnoid or epidural spaces.

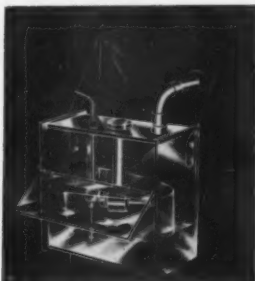
The tubing is available in two diameters for various needs. Four outfits of tubing with proper needles are offered for such special purposes as spinal and epidural anesthesia, intravenous injection, blood transfusion and intermittent intramuscular injection and hypodermoclysis. **Becton, Dickinson & Co., Dept. MH, Rutherford, N.J.** (Key No. 380)

Humidifier


An effective method of administering vaporization, humidity or inhalation therapy to patients with respiratory infections is offered in the new O-Plus Humidifier. It is a free-acting nebulizer creating high humidity, combining accurate high humidity with high oxygen content. The humidifier automatically

establishes a fixed intensity, spread, velocity, volume and quality of fine fog.

The new humidifier is designed to be adaptable to any oxygen tent and to meet every requirement of sensitivity or range. It produces controlled high or low humidity up to 100 per cent, responds to sensitive adjustments, has no moving parts, has capacity for all day use, an ice chamber for cooling and is easy to install. It can be attached directly to the oxygen regulator to save space or it can be attached to a face mask for direct administration of oxygen or humidity. It is easy to service, is



compact and ruggedly constructed. **O-Plus Mfg. Co., Dept. MH, 97-02 150th St., Jamaica 2, N.Y.** (Key No. 381)



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FAIRBANKS-MORSE GENERATING SETS

Power failure can start a lot of trouble for theater operators, hospitals, institutions, churches, schools, police, fire and other municipal departments. Injuries, loss of life, and property damage can lead to lawsuits and heavy damage claims.

Protect yourself. Install a Fairbanks-Morse Generating Set for quick power during emergencies. Available in a capacity to meet your needs. For details, see your local Fairbanks-Morse dealer, or mail coupon.



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We are interested in emergency power generating sets. Send details.

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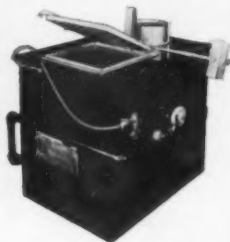
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in 4, 9 or 11 bushel capacity

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"Our whole staff
thinks our Carrara Glass walls are great!"



Architects: Marlier, Wolfe & Johnstone, Pittsburgh, Pa.

● There are compelling reasons for the medical profession's enthusiastic approval of Carrara Structural Glass for the critical needs of the modern hospital. Here is a *true* glass, assuring excellent sanitation. It is a *permanent* wall covering. It cuts maintenance costs, because it is so easy to keep clean. And its cheerful, scientifically correct colors help create a happier atmosphere.

Carrara Glass has a flawless, flat, reflective surface. It is homogeneous in structure, impervious to water, acids, chemicals and grease. It does not absorb odors. There is no checking, crazing, staining or discoloring with age. And it is available in ten attractive colors. One of these, Tranquil Green, is especially suited to the requirements of operating rooms.

Whether you are contemplating new building or remodeling, we suggest that you give serious thought to Carrara Glass for the walls of operating and treatment rooms, laboratories, bathrooms, washrooms, kitchens, corridors. Your architect is familiar with all the advantages of Carrara Glass, so consult him. Meanwhile, why not write for complete information on this quality structural glass? Pittsburgh Plate Glass Company, 2191-1 Grant Building, Pittsburgh 19, Pa.

CARRARA

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PITTSBURGH PLATE GLASS COMPANY

Adjustable Arm Board



Designed to fill every positioning requirement rapidly and conveniently, the S-1576-L Adjustable Arm Board fits practically every siderail in use. Adjustment and fastening hand-screws are located beyond the siderail of the table and are easily accessible at all times. The board may be attached, adjusted or removed from the table in a matter of seconds without disturbing the patient or moving the mattress. Height adjustment of over four inches is provided to compensate for any mattress. Provision is made to attach the Shampaine double hook irrigator rod or other 1/2 inch rod on either side of the arm board.

The board is made of plywood with black satin Formica top, rounded corners, in a length of 24 inches, 8 inches wide at its extremity. Serrated jaws on radial and leveling adjustments assure positive locking, even when handscrews are not

completely tightened. Shampaine Company, Dept. MH, 1920 S. Jefferson Ave., St. Louis 4, Mo. (Key No. 382)

Rubberized Paint

Wallhide Rubberized Satin Finish is a new interior paint with unusual decorative qualities combined with durability and washability. It has the appearance and usefulness of a flat wall paint with rubber-like characteristics. The paint requires no primer and is easily applied by brush, spray or roller coater on any interior wall or ceiling surface, including new or old plaster, paint, wallpaper, wallboard, brick, concrete, cinder block, wood or primed metal. The rubber-like film prevents grease, lipstick, finger smears and ink spots from penetrating the surface.

The new product should be of particular interest in hospitals and other institutions since it has no objectionable odor and dries to a smooth finish in approximately one hour. If a second coat is desired, it can be applied after four hours. As a result, rooms need not be kept vacant for long periods for rehabilitation. The paint does not crack or chip as the film remains flexible, and it can be washed. Pittsburgh Plate Glass Co., Dept. MH, 632 Duquesne Way, Pittsburgh 22, Pa. (Key No. 383)

Sentinel Mixing Valves

Washing in water of a predetermined temperature that does not change due to fluctuating water supply line pressures is possible with the new Speakman Sentinel Elbow and Knee Operated Mixing Valves. Designed for use in scrub-up rooms and other areas where elbow and knee operation is desirable, the new valves have a patented operation which guards against sudden surges of steaming hot or icy cold water. The discharge temperature set by the user is held steady throughout its use.

The "Floating Sentinel" is an engineering achievement which employs no springs or thermostats but operates automatically on water pressure alone. It is easily accessible and can be quickly removed if necessary for inspection or cleaning, without shutting off the water supply. The new valves are available



with elbow-action mixing valve, in two types, and with knee-action mixing valve. Speakman Company, Dept. MH, Wilmington 99, Del. (Key No. 384)



Only 
the BEST is
good enough!

By virtue of two recent improvements, effected at no increase in price, Crescent Blades are now finer than ever:

1. Now made of a new, high-carbon, finer-grain SWEDISH steel—long acknowledged the finest for cutting edges.
2. Now aluminum foil-wrapped—for moisture-proofing against any climate, assuring fresh top-quality performance under all conditions.

The Crescent Blade is thus more than ever the "Master Blade" for the Master Hand! Samples on request.

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CRESCENT SURGICAL BLADES
AND HANDLES

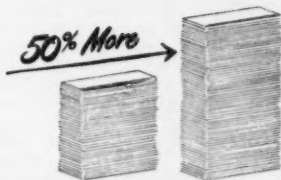
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in every 4 towels
used in industry,
schools, hospitals, and
other institutions
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sanitary service

is insured when a clean fresh individual towel is used only once, then discarded. A sanitary Nibroc towel is so economical—costs but a fraction of a cent.



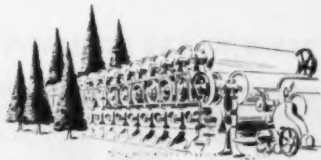
less servicing

is required with Nibroc cabinets. They hold up to 50% more towels than ordinary cabinets. A special adhesive bonds them to tile, glass or wood without drilling.



fast flexible service

is assured no matter where you are located. *Nationwide* distribution and high mill production put Nibroc towels in your hands when you need them.



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of Nibroc towels is available year in and year out—made by one company from timber-cutting to finishing. One Brown Company machine alone, called "Mister Nibroc," produces nearly 30 million towels daily.

Why not specify Nibroc for your washrooms, and your floor laboratories and utility rooms? Doctors, nurses and patients appreciate the greater absorbency and wet-strength of these soft lint-free towels. Nibroc is the world's largest selling towel for industrial and institutional use.

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KOWTOWLS • BERMICO SEWER PIPE, CONDUIT & CORES • ONCO INSOLES • CHEMICALS

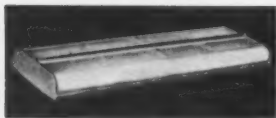
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Please send me data on Nibroc cabinets
and Nibroc towels.

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Title _____
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Holoflux Luminaire



The new 9300 series surface-attached Holoflux Luminaires simulate recessed construction because of their extreme shallowness of design. They have low brightness, high output, easy and continuous installation and minimum depreciation. Brightness control is provided across and along the axis of the lamps.

Features of the construction of the new units include easy removal of the Con-trols and snap shut hinged doors. The luminaires can take two or four fluorescent lamps of either the conventional bipin or the new instant-start single pin type. A small percentage of upward light illuminates the ceiling and there is complete absence of glare, even in long continuous runs. **Holophane Company, Inc., Dept. MH, 342 Madison Ave., New York 17. (Key No. 385)**

Plastic Flooring

A new vinyl plastic asbestos tile flooring is being introduced under the name

Arraflor. It is a resilient flooring, attractive in appearance and rugged enough for areas subjected to heavy traffic and other abuse.

The new flooring can be installed on, above or below grade and in areas where moisture conditions or the presence of fats, oils or greases might prohibit the use of other types of flooring. It is fire-resistant and is not affected by mild acid solutions or such solvents as gasoline, naphtha or alcohol. Arraflor is available in 18 marbled colors in 9 by 9 inch tile sizes, 1/8 inch thick. **B. F. Goodrich Flooring Div., Dept. MH, Watertown 72, Mass. (Key No. 386)**

Westex Timer

The Westex Timer is a new no-wind, long ringing interval timer designed for dark rooms and laboratories. This new style timer is adjustable up to 15 minutes and is designed for extreme accuracy. A limit knob may be set at any point on the timer for successive operations where the same time limit is required. The front of the new timer is slanted back so that it can be more easily read, and the case has corrosion resistant finish. **Westinghouse Electric Corp., Dept. MH, 2519 Wilkens Ave., Baltimore 3, Md. (Key No. 387)**

Air Sanitizer

A compact, recessed wall mounting unit has been introduced to provide ultra-violet radiation for confined areas. Known as the Model No. RSW201-U6 Air Sanitizer, the unit has a highly efficient parabolic reflector especially designed to concentrate and direct the maximum energy from the ultra-violet lamp to an angle that is above the horizontal, yet in such manner as to reduce to a minimum the reflection from low ceilings. The controlled reflection ensures complete upper irradiation of a room.

The unit has a housing of 20 gauge steel, finished in white baked enamel, and the reflector is of Alzak aluminum. It is built for flush mounting and is rigidly reinforced to prevent distortion during installation. Handy wiring compartments at each end of the housing aid in wiring and eliminate the need for additional outlet boxes. The fixture should be mounted seven feet from the floor. The required number of fixtures



for most installations can be computed from charts in the ultra-violet catalog. **Sperli Faraday Inc., Dept. MH, Adrian, Mich. (Key No. 388)**

DESIGNED WITH THE PATIENT IN MIND—



Maximum wear assured because Melrose skill has produced the top quality gown made to the exacting standards of a Government bureau. Fine fabrics, like white Sanforized hospital linen and unbleached hospital linen are used. Sizes: small, medium, large.

- ✓ DOUBLE NEEDLE STITCHING
- ✓ REINFORCED YOKE
- ✓ DOUBLE BAR-TACKED TIE TAPES
- ✓ FINISHED HEM
- ✓ CONVENIENT POCKET

MEDIUM — 37" LONG • LARGE — 39" LONG



PATIENTS GOWN of Unbleached Melrose Linene • Conforms to alternate recommendations of the U.S. Dept. of Commerce. Features extra neck binding and sturdy stitching, with double bar-tacking on tie tapes. Average length, 39". Small, medium and large sizes. Style 490.

Melrose GOWNS

STURDILY MADE for long wear and washability
REINFORCED at points of strain
FULL CUT for comfort
LOW PRICED for economy

GOWNS FOR INFANTS & CHILDREN

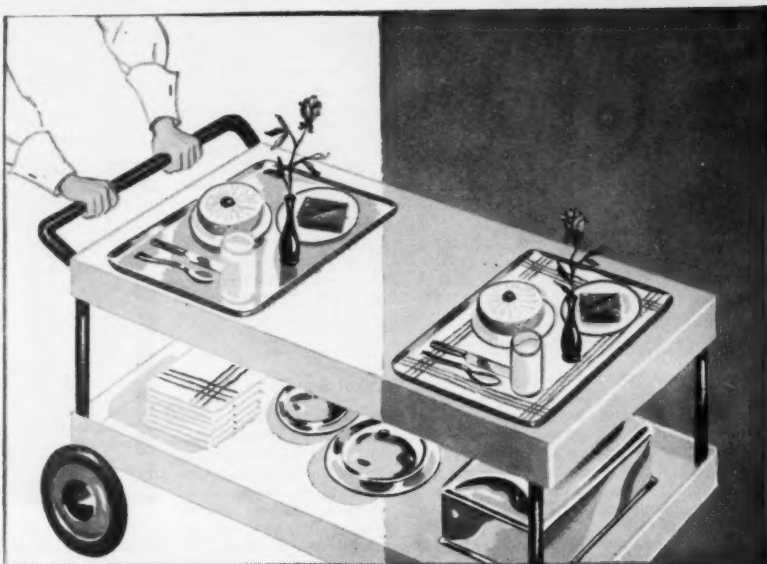
While Sanforized hospital linen, the sturdy washable fabric, is used for Melrose children's gowns (style 592) which feature the same high standards as our better adults gowns. Style 501 for infants, is made of soft, bleached white outing flannel.



Melrose HOSPITAL UNIFORM CO. INC.
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**In these times you are
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Hospitals are overcrowded—
more patients must be well-cared for—
and good napery is
indispensable to an
attractive, efficient
operation.**

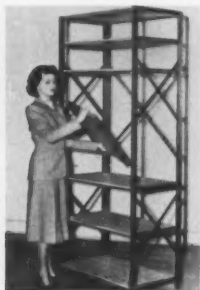
You can take good napery for granted . . . because SIMTEX doesn't . . .

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SIMTEX MILLS, DIVISION OF SIMMONS COMPANY, 40 WORTH STREET, NEW YORK 13, N. Y.

Steel-Wood Shelving



A complete line of adjustable steel-wood shelving is being manufactured by Lyon Metal Products. The new line combines sturdiness, strength and safety.

Rigid steel uprights support the hard wood shelves which can be set in at any desired levels. A pressed steel clip attaches each shelf to the steel upright without the use of bolts. The new shelving is available in dimensions of 3 feet in width, 1 or 1½ feet in depth and 7 feet in height. It is easy to install because of the minimum number of parts to be handled and shelves can be readily moved, dismantled or rearranged. Lyon Metal Products, Incorporated, Dept. MH, Aurora, Ill. (Key No. 389)

Radiation Detector

A new "Radiation Monitor" has been developed to permit direct radiation readings at a glance. The instrument weighs less than a pound and is about the size of a quart oil can. It is equipped with a self-contained power source and has neither tubes nor batteries. Radiation measurements are read from the monitor simply by noting the position of a pointer as it moves across a graded scale. The speed at which the pointer moves is in proportion to the strength of radiation. The sensitivity, coupled with a continuously-visible indication, will give warning of a radiation hazard in an area while there is still time to avoid excessive exposure. General Electric Co., Dept. MH, Special Products Div., Schenectady 5, N.Y. (Key No. 390)

Vertikal Sun Blind

As its name indicates, the Vertikal Sun Blind consists of vertical bands which may be opened to emit light and air or closed to provide shade and darkening. Made of ribbon in a choice of colors, the blinds combine the decorative qualities of draperies and curtains while controlling light and privacy. Plastic panels are also available.

The Celanese Multicord ribbon or

plastic louvers are attached to hooks at the top and bottom of the window and are easily removed for cleaning and as easily replaced. A single control rod gives complete control of the blinds with one turn. The blinds are well constructed and engineered for long wear. The ribbons are available in 28 decorator colors and may be dry cleaned or washed. Sun Vertikal Blinds are constructed to give maximum circulation of air and maxi-

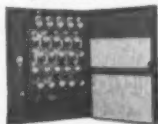


mum control of light. Sun Vertikal Blind Co., Dept. MH, 55 Mt. Vernon N. W., Grand Rapids, Mich. (Key No. 391)



MOORE KEY CONTROL*
OFTEN PAYS FOR ITSELF
IN LESS THAN 2 YEARS!

You owe it to yourself to investigate this modern system of key control. It saves money year in and year out by eliminating expensive repairs and replacement of locks and keys. What's more, it guarantees security, convenience and privacy. No wonder Moore Key Control is used throughout schools, institutions, hospitals, industry, government, transportation, communications, housing . . . wherever keys are used. Send for details today!

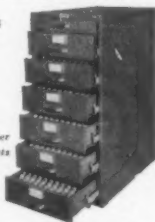


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every size
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Over 9,000 in service on two to 34 story buildings, saving 44 sq. ft. of usable floor space on each floor instead of stair wells.

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↑ **Armstrong's Rubber Tile** has the extra beauty frequently desired for floors in hospital lobbies and reception rooms. It is an extremely durable material with high resistance to wear and indentation. An exclusive Armstrong adhesive, recently developed, now permits this floor to be installed over grade-level concrete subfloors.

↓ **Armstrong's Linoleum** is an excellent flooring value for hospital corridors, wards, and private rooms. Moderate in cost, it provides a floor that's both attractive and durable. It can be maintained economically. The cushioning effect of the floor makes it comfortable to walk on, reduces the disturbing clatter of footsteps.



There's an Armstrong Floor for every hospital need

In choosing floors for hospitals, it is important that the special requirements of each area be taken into consideration. The lobby floor, for example, gets the heaviest traffic. Here, either Armstrong's Rubber Tile or Linotile® is a good choice because both have exceptional wearing qualities. In addition, they have outstanding beauty and color. One of the most popular resilient floors is Armstrong's Linoleum. It is moderate in cost and meets the needs of general hospital areas. Armstrong's Asphalt Tile is a low-cost flooring with unusual qualities of beauty and service. It is especially recommended for basement and grade-level floors. Where underfoot quiet and comfort are desired, Armstrong's Cork Tile is an excellent flooring. Call your Armstrong Flooring Contractor for help in selecting the right floors for your hospital.

FREE 20-PAGE BOOKLET brings you all the facts. "Which Floor for Your Business?" illustrates in full color and gives all the information about Armstrong's Resilient Floors and their uses. It will show you the advantages of each type of resilient floor and help you select the Armstrong Floor best suited for various hospital areas. Write to Armstrong Cork Company, Floor Division, 5707 State St., Lancaster, Pa.



Venetian Blind Washer



The Tornado Venetian Blind Washing Machine is a newly designed machine which quickly and economically cleans venetian blinds, including the cords and tapes. Blinds to be cleaned can be brought to a central location or the machine can be moved on its rubber rollers or carried on a small truck or platform to any desired location.

The Tornado is a cabinet type washing machine which is connected to a water line and to a standard electric outlet. Cold water is used with a special detergent. The motor and pump inject

the detergent into the water line. Blinds to be cleaned are suspended in a clear space and sprayed with the detergent solution which is not re-used. A valve controls the amount of detergent used so that a heavier solution can be employed for unusually dirty blinds. To rinse, clear water is obtained merely by switching off the motor. The machine should be operated on a concrete floor near a floor drain.

The cabinet is finished in hammerloid aluminum with chrome and plastic trim. The enclosed metal tank has a capacity of 28 gallons and is coated with rust resistant paint. The hose is long-wearing, oil and grease resisting plastic. Venetian Blind Equipment Co., Inc., Dept. MH, 101 S. 44th St., Philadelphia 4, Pa. (Key No. 392)

Blood Sugar Test

The Melitest is a new kit designed to determine easily and quickly the amount of sugar present in the blood. Only a single drop of blood is needed with the Melitest method for the simple procedure which quickly gives the desired information. The kit can be taken to the patient's bedside or used in the clinic or out-patient department. Biochemical Methods, Inc., Dept. MH, 3200 Los Feliz Blvd., Los Angeles 39, Calif. (Key No. 393)

Fruit Juicer

The Zippy Juicer has recently been taken over by the Sweden corporation and is to be known as the Sweden Speed Juicer. The juicer has been improved to give greater efficiency in use.

All plastics and metals used in the juicer are impervious to fruit acids. The motor is a heavy duty 1/4 h.p. completely enclosed model. Feeding is automatic so that no plunger is required to press fruits into the juicer and the disintegrator knife severs juice cells without bruising, thus retaining the full vitamin content.



Sweden Freezer Mfg. Co., Dept. MH, 3401 Seventeenth Ave. W., Seattle 99, Wash. (Key No. 394)



New PLASTER CAST PADDING Saves Orthopedist's Time Gives Greater Patient Comfort

These pre-cut and pre-shaped pads let the orthopedist fashion his cast immediately around them. There is no time wasted shaping loose cotton. The pads, of soft quilted material, are tailored and sewn to exactly fit the joint. They help the fracture surgeon shape a perfect cast that is far more comfortable than one made with loose fibrous padding.

For a Complete Description
Call or Write

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MANUFACTURING COMPANY, INC.
WARSAW, INDIANA



MECHANIZED WASHROOM in modernized laundry of Patton State Hospital, Patton, Calif. At right are two 42 x 96" CASCADE Unloading Washers with Full-Automatic Washing Controls. In foreground, two 54" NOTRUX Extractors. Photo courtesy of American Laundry Machinery Company.

OPENING THE WAY TO SAVINGS ...with push-button equipment of MONEL

Mechanized laundry machines roll up records nearly everywhere! Here at California's Patton State Hospital, for example . . .

The laundry department was having trouble keeping pace with the demands of this 4,367-bed institution. So the hospital enlarged the department — and put in the latest work-saving equipment. (Most of it is run by patients, under supervision of staff members.)

What a change this made! Piles of soiled linen disappeared. Out of the modernized laundry department now flows an abundant supply of ready-for-service towels, sheets, pillow cases and gowns.

And Patton State Hospital is getting this increased production even though 12 operators have been transferred to other work! *What's more*, they've cut a full day from the work week. And they are saving money on supplies . . . on water . . .

on steam . . . on power.

It's easy to see why. Push-button operation saves time and effort. The Washers *unload automatically* by merely pressing buttons. Automatic Controls perform all washing operations, *unattended* . . . They don't guess, don't forget. Supplies are measured mechanically. *There's no skimping, no waste.*

Simply pressing a button changes Extractor loads in *less than a minute* . . . does away with manual handling of heavy, damp work. With mechanized equipment you get maximum economy — and washing quality that's always up to the standard you demand.

With Monel® equipment, too, you

needn't worry about rust or corrosion. Monel resists soaps and detergents . . . alkalis . . . starches . . . dilute bleaches . . . fluoride sour. Washer cylinders and extractor baskets stay smooth, don't develop pits and rough spots.

Right now, of course—with America's defense program calling for more and more metal—you may not be able to obtain all the Monel equipment you'd like to have. Even so, it will pay to find out how mechanization can improve your operations.

For expert aid in planning a smooth-running, efficient laundry department, write your laundry equipment manufacturer.

The International Nickel Company, Inc., 67 Wall Street, New York 5, N. Y.



Mechanize with Monel!



Pharmaceuticals

Pyromen

Pyromen is a sterile, nonprotein and nonanaphylactogenic bacterial component, supplied as a stable colloidal dispersion for intravenous use. It is recommended by the manufacturer for use in certain allergic, dermatologic and ophthalmic disorders and in neurosyphilis. It is supplied in 10 cc. vials containing 10 gamma per cc. It should be kept under refrigeration, preferably at a temperature of 2 to 10 degrees C. **Baxter Laboratories, Inc., Dept. MH, Morton Grove, Ill. (Key No. 395)**

Methostan

Methostan, brand of methandriol, a steroid chemically closely related to methyltestosterone, is designed to provide beneficial protein anabolic effects without undesired androgenic action. It is indicated in retarded growth and constitutional diseases accompanied by protein wastage when such conditions do not respond to diet or to more specific therapy. It is supplied in aqueous suspension in vials of 10 cc. and in bottles of 30 and 100 tablets. **Schering Corporation, Dept. MH, Bloomfield, N. J. (Key No. 396)**

Pyrapar

Pyrapar "Ulmer" brand of pyrilamine bromtheophyllinate for the relief of menstrual tension, motion sickness and nausea of pregnancy is supplied in tablet form. The safety of the drug, when given in proper dosages, has been confirmed by clinical and experimental studies. It is supplied in 50 mg. tablets in bottles of 100, 500 and 1000. **Ulmer Pharmacal Co., Dept. MH, 412 S. Sixth St., Minneapolis 15, Minn. (Key No. 397)**

Name Change

Kalpec is the new name given to Wyeth's Kaomagma with Pectin. There is no change in the formulation of the product. **Wyeth Incorporated, Dept. MH, 1600 Arch St., Philadelphia 2, Pa. (Key No. 398)**

Proferrin

Proferrin is a rapidly effective, relatively non-toxic preparation for intravenous administration in the treatment of hypochromic microcytic anemia. It is a stable, sterile solution of saccharated iron oxide containing the equivalent of 20 mg. of available iron per cubic centimeter. **Proferrin Sterile Solution, ad-**

ministered by slow intravenous injection, is supplied in 20 cc. vials. **Sharp & Dohme, Inc., Dept. MH, Philadelphia 30, Pa. (Key No. 399)**

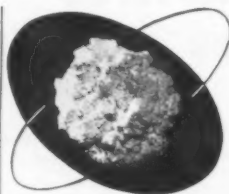
Aquasperse Vitamin A C D Drops

Aquasperse is an aqueous solution of synthetic vitamins A, C and D, indicated for patients who do not tolerate natural sources of the vitamins it contains. Since the vitamins are synthetic, Aquasperse is hypoallergenic. It quickly disperses in water, milk, fruit juices and other aqueous fluids. The product is supplied in bottles of 15 cc. and 30 cc. with droppers. **White Laboratories, Inc., Dept. MH, 113 N. 13th St., Newark 7, N.J. (Key No. 400)**

Clusivol

Clusivol is a comprehensive formula for use when extensive dietary reinforcement with essential vitamins and minerals is required in the treatment of the aging patient, before and after surgery and in other conditions. Each capsule contains vitamins A, B complex, including B₁₂, C, D, E, folic acid and minerals. **Ayerst, McKenna & Harrison Ltd., Dept. MH, 22 E. 40th St., New York 16. (Key No. 401)**

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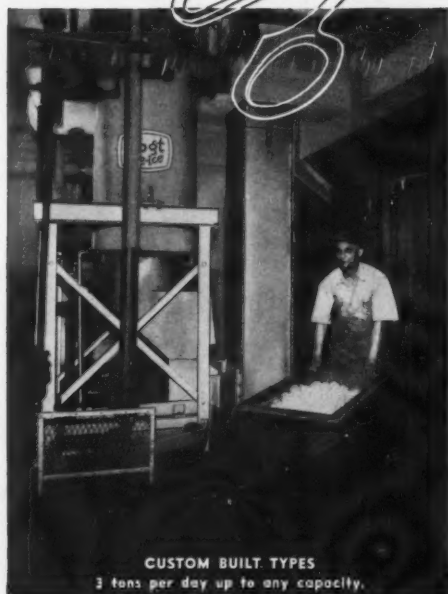
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SAVES LABOR: Being wholly automatic in operation and discharging ice in its ultimate sized form, the self-contained Tube-Ice Machine unit requires no labor and only a minimum of supervision.

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HENRY VOGT MACHINE CO., Louisville 10, Kentucky

BRANCH OFFICES: NEW YORK, PHILADELPHIA, CLEVELAND, CHICAGO, ST. LOUIS, DALLAS, CHARLESTON, W. VA.

Patent Nos.: 2,200,424 - 2,239,234 - 2,356,308 - 2,444,514 - 2,452,148.
Other patents pending.

Product Literature

• Starting out with a discussion of "what makes automatic air conditioning installations completely successful," a new 72 page booklet issued by Minneapolis-Honeywell Regulator Co., 2747 Fourth Ave., S., Minneapolis 8, Minn., continues with detailed and technical information on "Automatic Controls for Air Conditioning and Heating." Engineering data, including tables and graphs, are included. (Key No. 402)

• An effective solution to the dust annoyance problem is offered in a new brochure entitled "Gulf Sani-Soil-Set" issued by Gulf Oil Corp., Gulf Bldg., Pittsburgh 30, Pa. Information is given in the brochure on how the Gulf Sani-Soil-Set is used, what it does and how it is applied. (Key No. 403)

• Care of the cerebral palsied child can be facilitated through the **Varo-Met Cerebral Palsy Chair-Brace**. This device is described and its uses discussed in a booklet available from DePuy Mfg. Co., Inc., Warsaw, Ind., distributors of the chair which is designed for training the cerebral palsied child. Full details on the chair, its operation and its application to these cases are given in the booklet which is well illustrated. (Key No. 404)

• An attractive and practical message pad has been designed by Landers, Frary and Clark, Stanley Insulating Division, New Britain, Conn. Designed to build patient morale and relieve some of the visitor load in the hospital, the pad consists of a series of sheets with attractive drawings on which a message is printed, details to be written in, to inform the patient of telephone calls during his hospital stay. (Key No. 405)

• An attractively planned and executed booklet, printed in full color, has been released by Minnesota Mining and Manufacturing Company, 900 Fauquier Ave., St. Paul 6, Minn., on Scotch Surgical Drapes. Entitled "Announcing . . . A New Approach in Surgical Draping," the booklet gives full information on these surgical drapes which are made of plastic film and which can be adhered to the skin around the operative area. The story of the development of Scotch Surgical Drapes, the types available and text and pictorial descriptions of their uses are covered. (Key No. 406)

• A new folder has been issued by General Lamps Mfg. Corp., Elwood, Ind., "Introducing Contempo General's New Lamps with the Safety Tip Feature." In addition to full catalog information on the products, all floor and table lamps are illustrated. (Key No. 407)

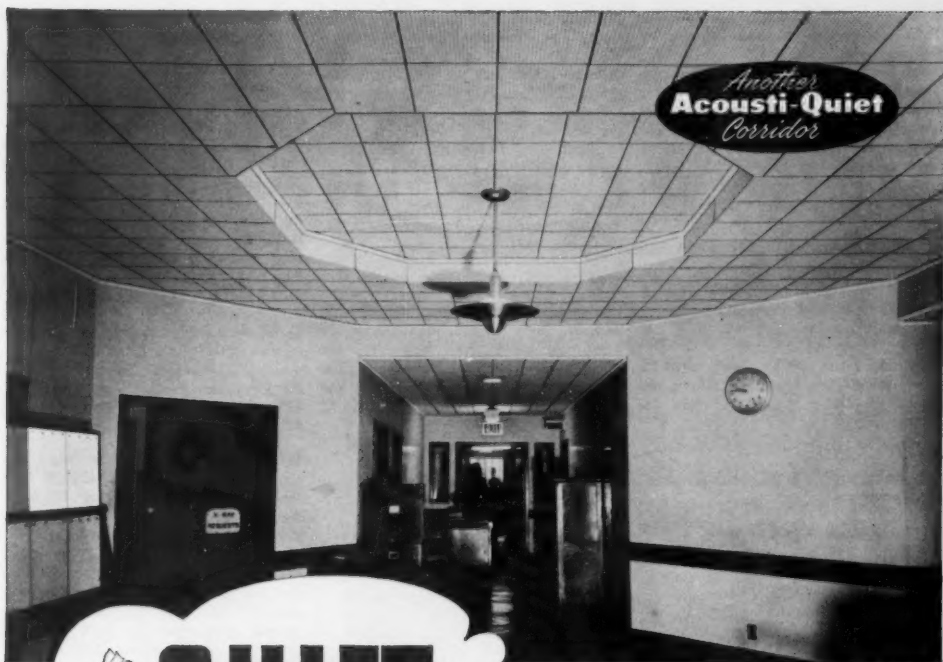
• "How to Cut Maintenance Costs With Venetian Blinds for Schools, Hospitals, Hotels, Office Buildings" is the title of a booklet recently released by Hunter Douglas Corp., 150 Broadway, New York 7. Interesting facts on venetian blinds and how they serve to regulate light, control ventilation, assure privacy and enhance appearance, as well as factual information on the blinds themselves, is followed by data on Flexalum blinds and Flexalum plastic tape which does not hold dirt. (Key No. 408)

• Accessories for use with iron lungs are illustrated with photographs and line drawings in a leaflet entitled "For All Iron Lung Patients" issued by Warren E. Collins, Inc., 555 Huntington Ave., Boston 15, Mass. (Key No. 409)

• A new catalog on "Fenestra Steel and Aluminum Building Panels" has been released by Detroit Steel Products Co., 2250 E. Grand Blvd., Detroit 11, Mich. The 38 page catalog contains valuable data for those interested in economical construction of schools, hospitals and other institutional buildings. Panel selection tables are provided as a guide to choice of the most economical Fenestra panel for a given need. The catalog has been revised to represent current practice and contains numerous photographs of installations. (Key No. 410)

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THE CELOTEX CORPORATION, 120 S. LA SALLE ST., CHICAGO 3, ILLINOIS

• A new colorful booklet on Vericolor Television System has been released by Remington Rand Inc., 315 Fourth Ave., New York 10. Entitled "New Color Television Is Here for Government, for Business, for Education," the booklet illustrates in color and describes the use of this medium in teaching surgery to large groups who, through this system, are able to get close-up views of the field of operation. (Key No. 411)

Book Announcements

Clement, "Nitrous Oxide-Oxygen Anesthesia," 3rd ed., 369 pp., \$6.50. Lea & Febiger, Dept. MH, Washington Square, Philadelphia 6, Pa. (Key No. 412)

Cecil and Loeb, "A Textbook of Medicine," 6th ed., 1627 pp., \$12. Davis and Sheckler, "DeLee's Obstetrics for

Nurses," 15th ed., 673 pp., \$4.50. Dorland, "The American Illustrated Medical Dictionary," 22nd ed., 1736 pp., \$10. Noller, "Chemistry of Organic Compounds," 885 pp., \$7. Sellev and Furfey, "Sociology and Social Problems in Nursing Service," 3rd ed., 391 pp., \$3.75. Williams and Brownell, "The Administration of Health Education and Physical Education," 4th ed., 439 pp., \$3.75. W. B. Saunders Co., Dept. MH, W. Washington Square, Philadelphia 5, Pa. (Key No. 413)

Suppliers' News

Gudebrod Bros. Silk Co., Inc., 225 W. 34th St., New York 1, manufacturer of non-absorbable sutures, announces the opening of new office at 991 Merchandise Mart, Chicago 54, to speed up sales and service in the Mid-West area. Calvin C.

Schrader has been appointed manager of the new office.

Eli Lilly and Company, Indianapolis 6, Ind., manufacturer of pharmaceuticals, announces the completion of a three story extension to the south wing of the Lilly Research Laboratories to keep up with the stepped up pace of medical and pharmaceutical research. The new wing has specially constructed sterility booths for biological testing, an air conditioned chromatography laboratory, a "germ free" laboratory for tissue culture studies and other refinements to meet the needs of highly specialized research technics.

D. W. Onan & Sons, Inc., manufacturer of emergency lighting equipment, announces the removal of its offices from 39 Royalston Ave., Minneapolis 5, to 6251 University Ave., Minneapolis 14, Minn.

THIS COUPON is provided for your convenience in requesting additional information.

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| <input type="checkbox"/> 390 Radiation Detector | <input type="checkbox"/> 411 "Vericolor Television" |
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MAIL TO Readers' Service Dept., The Modern Hospital Publishing Co., Inc.
 919 N. Michigan Ave., Chicago 11, Ill.

Will Ross, Chairman of the Board and founder of Will Ross, Inc., 4285 N. Port Washington Rd., Milwaukee 12, Wis., died on May 31 after a long illness. Mr. Ross was not only a pioneer in the hospital and sanatorium supply field but was prominent in activities connected with the control of tuberculosis. He was elected president of the National Tuberculosis Association in 1944 and was active in the Wisconsin Anti-Tuberculosis League. In addition, he was a director of the Red Cross, the Y.M.C.A. and Milwaukee-Downer College. He has been well and affectionately known in the hospital field for several decades.

C. M. Sorensen Co., Inc., manufacturer of laboratory equipment, announces removal of its offices from 403 E. 62nd St., New York 21, to 50-19 47th Ave., Woodside, Long Island, N. Y.

Richard E. Thibaut, Inc., manufacturer of washable wallpaper products, announces removal of its offices from 269 Madison Ave., New York 16, to 44 E. 53rd St., New York 22.

U. S. Vitamin Corp., 250 E. 43rd St., New York 17, manufacturer of vitamin and other pharmaceutical products, announces the purchase of Arlington Chemical Co., Yonkers, N. Y., also manufacturers of pharmaceuticals. The present Arlington Chemical Co. plant, together with new buildings to be constructed at the site in Yonkers, N. Y., will be utilized to enlarge the services of both U. S. Vitamin and Arlington to the medical and pharmaceutical professions.

J. O. Zimmer, president and founder of Zimmer Manufacturing Co., Warsaw, Ind., died in March after a brief illness. Mr. Zimmer was well known in the field of orthopedic appliances and had served the hospital field, through his company, for many years.

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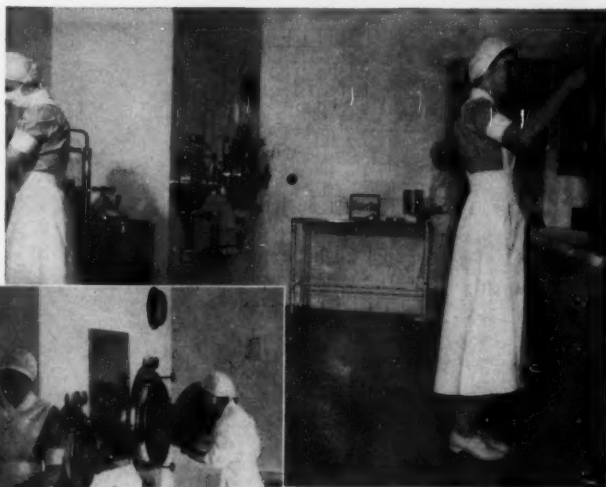


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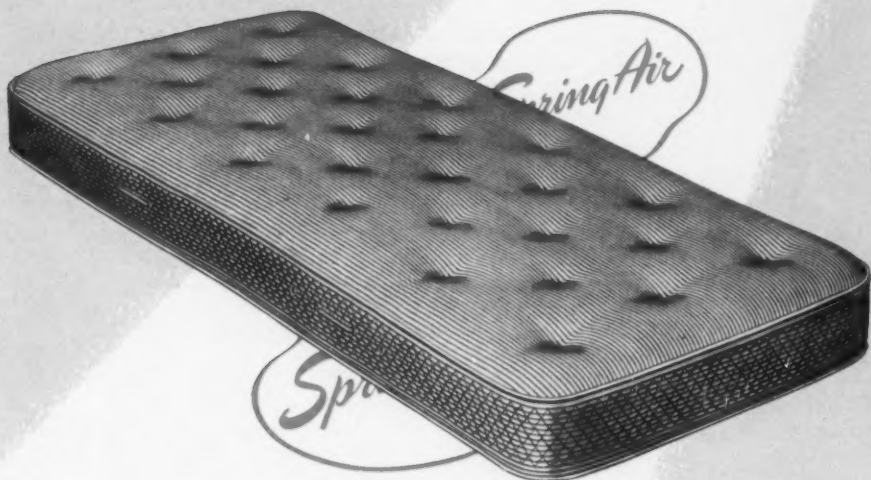
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